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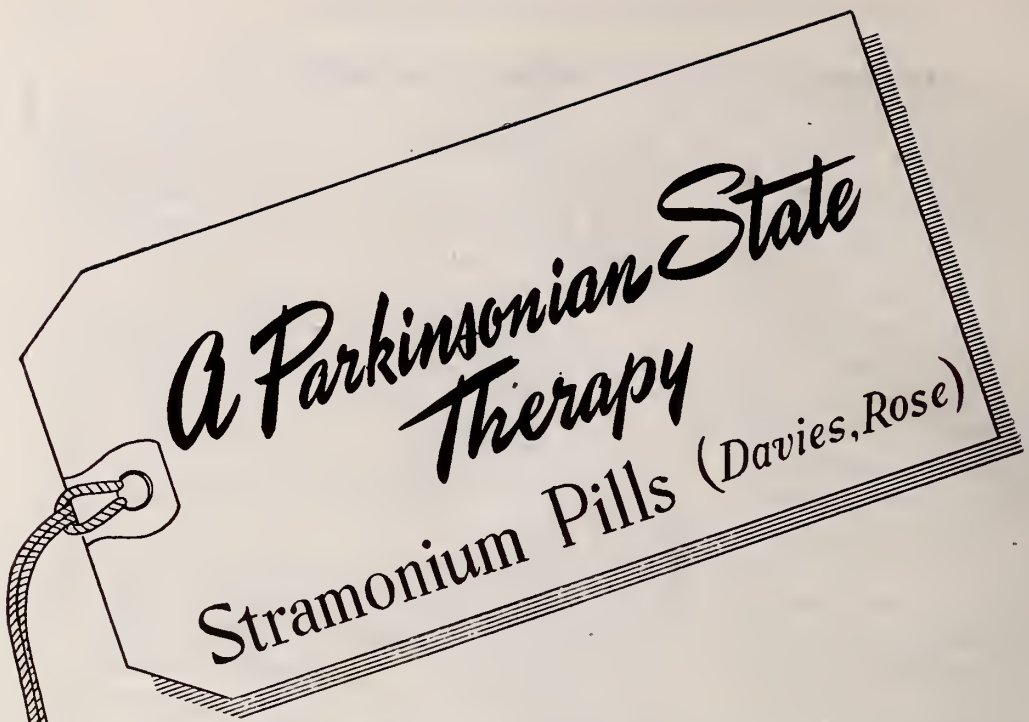
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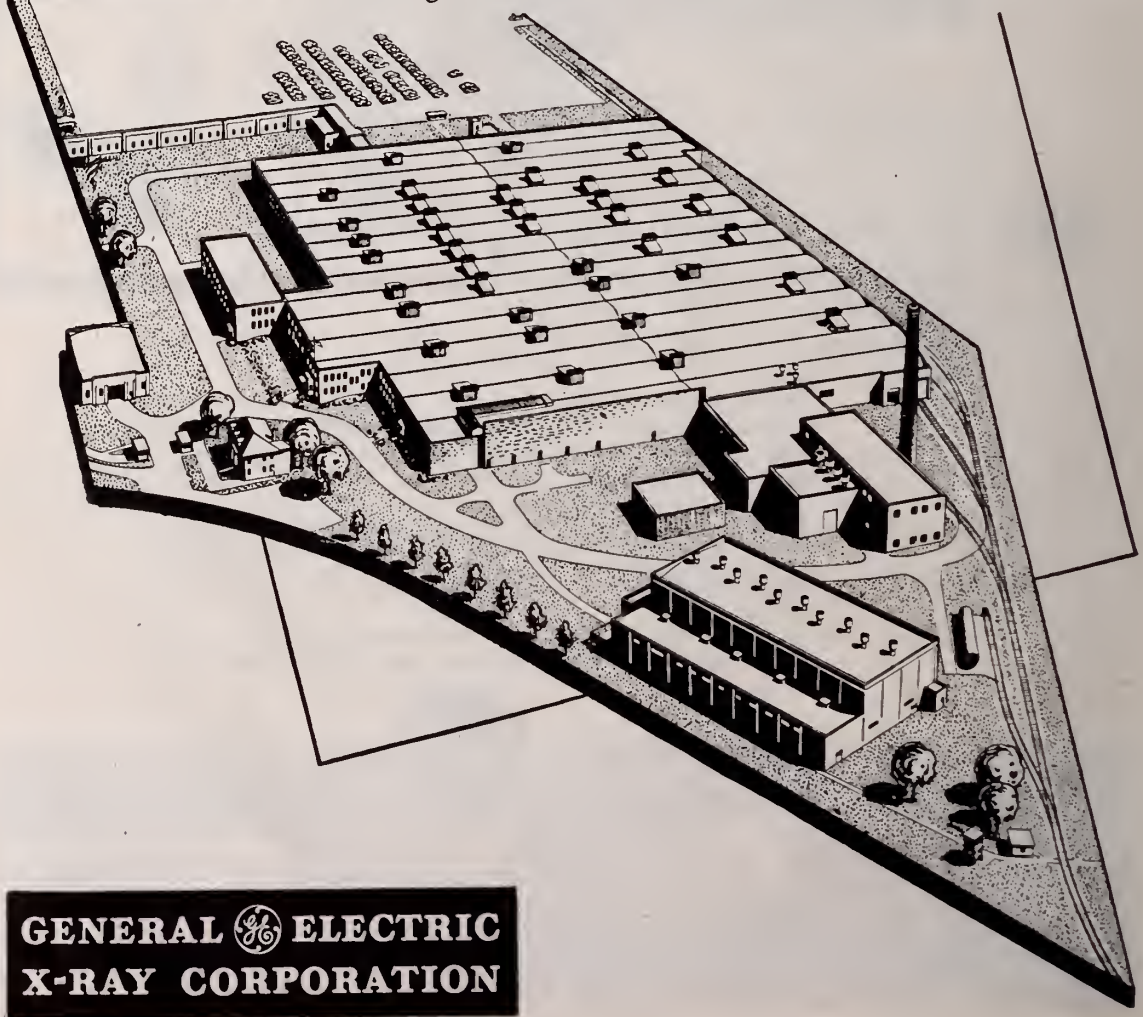
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1 Poppe, J. K. J.A.M.A. 129: 435 (Oct. 6) 1945.



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1. Bunn, P. A.: in Conferences on Therapy: New York State J. Med. 46:527 (March 1) 1946. 2. György, P.; Evans, K. W.; Rose, E. K.; Perlingiero, J. G., and Elias, W. F.: Pennsylvania M. J. 49:409 (Jan.) 1946.

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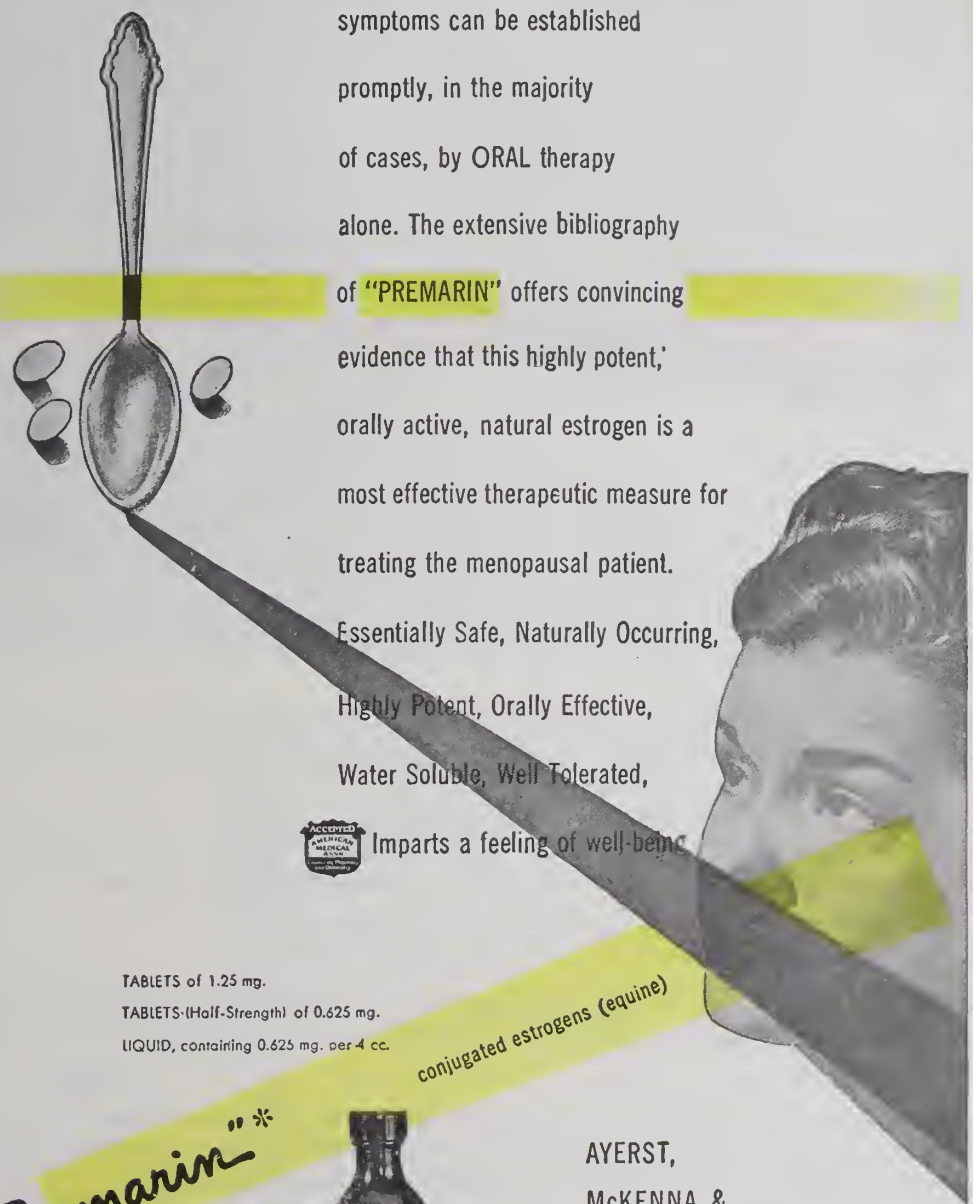
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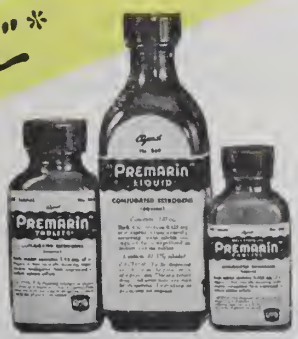
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GROUP PRACTICE COMES OF AGE

The establishment this month of a full-partnership group in Newark throws into sharp focus the entire question of the status of group practice. New Jersey is already known as the seat of one of the oldest groups in the country—the Summit Medical Group, which has accumulated a quarter of a century of successful experience. Because it will pool all income from patients, the new Newark Clinical Group comes even closer to the Medical Group Practice Council's definition which is: *an association of physicians of different skills, using medical equipment and administrative personnel in common, with a formal pattern of professional collaboration, and a unified administrative and financial organization.*

It is expected that 1947 will see the birth of many new medical groups in the east—the one area in the country where this type of organization has flourished least. Nonparticipants will view this trend with attitudes varying from tongue-in-cheek curiosity to outspoken hostility. Opponents of group practice will make numerous criticisms, chief of which will be these: that it means dividing one patient among numerous specialists; that the personal physician-patient relationship will be blurred; that knowing that specialized help is just across the hall, each doctor will pass the buck to his collegue, thus narrowing his own professional horizon; that for the same reason, there will be a tendency towards overconsultation, so that any patient who comes in with a hang-nail or a sore-throat will emerge with an electro-encephalogram and a Rubin test; that the business manager will encroach into the field of professional policy; that senior members of the group will dominate the professional activities of the junior physicians; and even that the security of income will stifle the doctor's ambition!

While some of these "arguments" sound capricious, it must be conceded that they are usually advanced in good faith by honestly troubled observers. And the answer is also a matter of good faith. If a group is composed of physi-

cians who individually are skillful and ethical (and this is certainly true of both the Summit and Newark groups) then it is gratuitous to suppose that they will undergo a professional or moral transformation by entering a group. Honest doctors will make honest groups.

Group practice will be appealing to the younger physician who is otherwise likely to sit around a half-filled office for some years watching time and idleness dull the sharp edge of his freshly acquired knowledge and skills. The group does offer him the chance of starting in high gear. To the older doctor it holds out a different appeal: a schedule with regular days off plus winter and summer vacations without loss of practice. The steady growth of groups all over the county attest to the value of this kind of organization to the patient.

The west is still the seat of most medical groups. The tide is moving east however, and this new year is certain to see the establishment of many groups along the Atlantic seaboard. Since several decades of nationwide experience have mellowed these once primitive and experimental organizations, our new local groups will spring into life already mature. The sentimentalist who sits on the sidelines may nostalgically mourn the loss of individualism, and the cynic may quip about the difference between giving a patient a work-up and giving him the works, but the tide will move on in spite of skepticism or expressions of doubt, and the solo practitioner can do no more than view the trend with interested and sympathetic curiosity. And in the tradition of the profession, he will wish the pioneers well.

OUR HOME OFFICE

You own a pleasant and stately mansion in the residential west end of Trenton, a dignified and roomy building that serves as the physical and structural symbol of organized medicine in New Jersey. Ours is such a small and compact state that its capital city is scarcely more than an hour or two away from any part of New Jersey. We have a right to hope therefore that most of our members will have some occasion to stop in at the Society Home now and then. You should see for yourself this building which, to the public, stands for our society much as the dome in Washington is the symbol for the national government. You will see the efficient business office of the Society, the commodious auditorium, the numerous cheerful committee rooms, the editorial office of this Journal, the mailing room, the sun drenched Woman's Auxiliary solarium, and the cozy long-tabled Trustees' chamber. Here you will find a mass of information about the medical profession of New Jersey—the populations and areas of the counties, the numbers of practicing physicians in each area, the addressess of your colleagues, back files of the Journal, of committee minutes and of reports of all sorts. Professionally this is your Home, and the latch-key is out for any doctor in the state. Stop in and you will be assured of a cordial "Welcome home".

THE UNEASY YEAR

To most physicians, perhaps, 1946 was an uneasy sort of year. In New Jersey alone almost a thousand veterans left the medical corps to enter civilian practice. Many of them found themselves frustrated at their inability to obtain adequate office space, automobiles, medical equipment, or hospital connections. The organized profession, particularly at the national level, devoted much of its energies to fighting the Wagner-Murray-Dingell bill and the resulting discussions stimulated much serious thinking on the subject of medical economics.

The Medical Society of New Jersey had a busy year. The establishment of a home-town plan for the care of veterans was the most significant single development. New Jersey was one of the first four states in the country (and the first in the east) to set up such a plan. Indeed, General Hawley has assigned to our own Monmouth County full credit for having been the first medical unit to suggest a workable plan and the first to implement it. In 1946 the state-wide plan was formulated, the contracts signed, the fee schedule adopted, the first examinations and treatment accomplished, and the liaison office between V.A. and the Society created. When the definitive medical history of our state is written, it is probable that 1946 will stand out for this one project. But the year is notable for other accomplishments, too. It saw the birth of the first full-dress postgraduate educational program; and by strange irony, the death of a premature and unfortunate experiment in undergraduate medical education. The year was ornamented by one of the most successful Annual Meetings in our history. And in 1946 the State Health Congress was established—New Jersey's first venture in bringing together in permanent conference, the consumers as well as the purveyors of medical care. A detailed cancer program was finally established in 1946. And with the creation of the Committee on Laboratory Medicine, the Society gave official recognition to a growing major specialty. It was thus a fruitful year for organized medicine in New Jersey.

During 1946 the high command of The Medical Society suffered severe losses with the deaths, all in that year, of six important leaders of the Society. This was a cruel blow, for now more than ever is there need for mellowed judgment and ripe experience. Forever stilled at the counsel tables of the Society are the voices of Wells P. Eagleton, Christopher C. Beling, Samuel Barbash, Reeve L. Ballinger, Harry R. North and Andrew F. McBride.

The 1946 growth of the Medical Service Administration, of Blue Cross hospitalization projects, of the Veterans Care Plan, of group practice are all perhaps, milestones on the road of progress, and they are also tokens of a trend away from the individualized practice of medicine out of the little black bag. The enormous postwar increase in specialists, (and in practitioners who have set their sights at specialization) is another sign of the times, strongly underlined by the activities of 1946. No one seems to know what is coming next, for all this is but a reflection of the uncertainties and disappointments being played out on the larger stage of national and world policy. Nineteen forty-six was a year that raised many, many questions. It is to be hoped that 1947 will be a year than answers some of them.

ORIGINAL ARTICLES

SPONTANEOUS RUPTURE OF THE SPLEEN

REPORT OF A CASE

THOMAS H. ANDREWS, M.D., Matawan, N. J.

Spontaneous rupture of the spleen has been reported frequently enough to remove it from the class of medical rarities. It is still, however, unusual for the average practicing physician to encounter a case. It is possible that it may occur more often in the near future because malaria is by far the most common inciting cause. Certainly many veterans are returning to the United States with malaria and most of them are subject to recurring attacks.

Any abdominal catastrophe in a veteran during a malarial exacerbation deserves consideration as a possible rupture of the spleen. These facts would seem to warrant the reporting of the following case although in this instance malaria was not the causative agent. Had the diagnosis been suspected and the proper supportive therapy instituted a fatality might have been prevented.

The patient was 35 years old. He had been discharged from the Army a few weeks previously but had served his entire time in the continental United States. He was seen at his home on the morning of his hospital admission. The referring physician had given him one-quarter grain of morphine, the symptoms and signs at that time being typical of a perforated peptic ulcer. He had ben drinking heavily since returning home but he did not drink during the day and had been working steadily in the commercial greenhouses maintained by the family. The patient stated that he had been having painful indigestion periodically for about six months, the attacks having begun while he was in the Army. He described the pain as fairly severe, spasmodic, and always located in the epigastrium without radiation. Onset was usually about one hour after eating and he had always obtained relief by taking bicarbonate of soda or milk. He attributed this indigestion to alcohol and had not consulted a physician.

On the day of admission he was seized with epigastric pain similar to the previous attacks but much more severe. After his pain subsided, he went downstairs to breakfast and drank a small amount of coffee. He then fell to the floor, grasping his abdomen and thrashing about with pain. Members of his family carried him to his bed and called a physician. He had had two episodes of vomiting since the onset of the pain.

He was a large, well-developed male, 74 inches tall, weighing 230 pounds. He was apparently in severe agony, having obtained no relief from his previous medication. He was lying on his abdomen and moaning with pain. There were no signs of shock except profuse diaphoresis. Color was good. Pulse was 80 and blood pressure 140/80. Temperature was 99°. He complained of severe, generalized, abdominal pain and gained the supine position only after great and painful effort. He did not appear greatly dehydrated and abnormal findings were confined to the abdomen. Tenderness and rebound tenderness were present, but were most marked in the upper quadrants. The upper half of the abdomen was rigid but not board-like. It was less marked but definitely rigid through the lower half. Liver dulness was not decreased and abdominal tympany seemed to be normally distributed. No abnormal dulness was noted in the flanks. Except for the absence of board-like rigidity, the picture was typical of perforated peptic ulcer and after being given another quarter grain of morphine, the patient was admitted to the Monmouth Memorial Hospital at Long Branch with that diagnosis.

Acute pancreatitis was also considered and an emergency serum amylase was done on admission. Wangansteen suction was instituted and an infusion of 2000 cubic centimeters of glucose in saline was given. A flat abdominal x-ray was not taken and this was probably fortunate as it would not have shown free intraperitoneal air and would not only have caused the patient unnecessary activity and discomfort but might have unnecessarily delayed operation.

Three hours later, the patient said that his pain was less severe and he appeared more comfortable. His abdominal rigidity, however,

seemed more pronounced and severe upper abdominal tenderness was present, most marked in the epigastrium. The serum amylase was normal as were the other laboratory examinations with the exception of the finding of a mild secondary anemia. His red blood count was 3,800,000 and his hemoglobin 75 per cent. The white blood count was 16,800 with 90 per cent polymorphonuclear leukocytes.

At 1 p. m. the patient was brought to the operating room with a diagnosis of perforated peptic ulcer. Pulse and blood pressure were still normal. He was given spinal anaesthesia and shortly afterward went into a moderate shock. As this happens occasionally with spinal anaesthesia (and since he appeared to respond to oxygen) little significance was attached to it. The abdomen was opened through a high, right rectus muscle splitting incision. When the peritoneum was exposed it was obvious that intraabdominal hemorrhage was present. Immediate blood typing was ordered and a plasma infusion was begun.

The peritoneal cavity was found to contain numerous large blood clots and considerable fresh, unclotted blood, the total amount being estimated at 3000 cubic centimeters. After most of the blood had been evacuated, liver and stomach were examined and found normal. As most of the blood seemed to be coming from the left upper quadrant, a left transverse extension was made from the original incision. The spleen was exposed with some difficulty as it had a very short pedicle and could not be elevated. A gaping laceration about 1½ inches in depth was readily visible in its free margin. The organ itself appeared smaller than normal. An attempt was made to close the laceration with a chromic intestinal suture on a fine, curved needle but the splenic tissue was too friable to hold even the needle. It was felt that splenectomy was the only possible procedure in spite of the fact that the patient's condition had become precarious and no peripheral pulse could be felt. A rapid cardiac pulsation could, however, be felt by the operator through the diaphragm.

The spleen was freed from the diaphragm, its pedicle was clamped, and the organ was removed. Immediately after clamping the pedicle, the patient's condition improved somewhat. His peripheral pulse became palpable, settled down to 120 per minute and remained at that level while the splenic pedicle was ligated and the abdominal wall closed with through-and-through sutures of heavy silk. His condition seemed fair and after dressings had been applied he was unstrapped preparatory to being transferred to a stretcher. He then very suddenly developed an episode resembling an attack of delirium tremens. He became noisy, abusive, agitated and over-active, requiring five people to hold him on the table. This lasted about 10 minutes, after which he became quiet. His pulse returned to 120 and was of fair quality. He was transferred to the stretcher and returned to his room where two quarts of blood had been prepared for him. When the attendants prepared to lift him from the stretcher to the bed they noted that he was not breathing, no heart sounds could be heard, and attempts to revive him were futile.

Post mortem examination was made by Dr. Julius A. Toren at the Marlboro State Hospital. The pedicle ligature was found to be in place and the abdominal cavity contained no free blood. The liver was moderately enlarged and the site of fatty infiltration. There was an odor of alcohol about the thoracic and abdominal viscera. The alcoholic content of the blood was found to be 125 milligrams per 100 cubic centimeters in spite of the tremendous blood loss and dilution of the remaining blood with fluid. The report on the spleen itself was: "Sections show an increase in leukocytes with compression of the sinuses. There are many plasma cells present. Some areas reveal islands of amyloid and there is enormous thickening of the arterial walls. The capsule is extremely thin. Gross examination revealed the organ to be extremely fragile." Microscopic diagnosis was acute splenitis, thought to be due to alcoholism. This last assumption was based on the fact that he was known to be a heavy drinker and also on the fact that no other evidence of an infectious process could be found elsewhere in the body.

COMMENT

In retrospect, the most obvious feature is the error in diagnosis. However, in the absence of the history of trauma or malaria and with none of the signs usually present in a massive hemorrhage, there was little to lead one to suspect the correct diagnosis. Operation would have been performed in any event but it would probably have been done sooner had

the correct diagnosis been made. The second error was failure to have blood typing done and to provide blood for transfusion before or during operation. This error of course was predicated on the error in diagnosis. Patients with perforated ulcer who are operated early seldom need transfusions and if they do it is usually during their convalescence and not at the time of operation. This illustrates the advisability of doing blood typing routinely on all emergency admissions to a general hospital.

This spleen was definitely diseased as evidenced by the pathologist's report and by the extreme friability of the organ. Practically no capsule was present as noted at operation and by the pathologist. The cause of the disease is obscure. The pathologist said it was due to alcoholism, basing the opinion on the history and the alcoholic saturation found at autopsy. The splenomegaly of alcoholism, however, is usually chronic and secondary to hepatic cirrhosis. The spleen then presents the findings resulting from chronic congestion and only moderate enlargement is present. The pathology here, except for one finding, would seem to indicate some acute process. It is easy, in retrospect, to theorize that the previous attacks of abdominal pain were due to splenic enlargement stretching the capsule and that the final episode was accompanied by such great enlargement that the capsule ruptured. Its small size at operation was due to the fact that the organ was practically exsanguinated.

The one possibly significant pathologic finding was the marked thickening of the arterial walls. Unfortunately, microscopic sections of other organs were not taken, the autopsy having been performed for legal rather than scientific reasons. It would have been of interest to know whether this was generalized. However, the possibility of a vascular disease such as periarteritis nodosa with rupture of a major splenic vessel must be considered as a cause.

CONCLUSION

1. A case of spontaneous rupture of the spleen is presented in the hope that it may focus attention on this condition and bring to mind the possibility of the diagnosis in patients with acute upper abdominal catastrophe, particularly those known to have malaria.

2. Acute splenitis, the secondary pathology causing the rupture, is reported for the first time, to the author's knowledge, as being due to alcoholism.

3. The typical symptoms of shoulder pain, air hunger and shock need not be present in rupture of the spleen despite tremendous intra-abdominal hemorrhage.

111 Main Street

EARLY RECOGNITION OF EPIDEMIC ENCEPHALITIS

Felix Frisch, M.D., Trenton, N. J.

The current winter season and our continued contacts with countries whose population suffers distress should make physicians in general practice more attentive to the emerging symptoms of epidemic encephalitis. Malnutrition reduces resistance and renders afflicted persons good culture media for viruses and bacteria.

The danger of overlooking such cases is increased by the protean polymorphism of the symptoms of encephalitis. Some cases are recognized only by affirmatively searching for accompanying signs. In view of the variability of the clinical picture some phenomena which may serve as signposts should be brought to the attention of the general practitioner. I limit my discussion here to the acute phase of the disease.

First let it be said that febrile cases of grippe-like illness ought to suggest at least the search for other symptoms.

DISTURBANCES IN SENSORIUM AND SLEEP

All possible degress of sensorial disturbance may occur. A lethargic state sometimes keeps patients in sleep of varying depth. For the most part they can be awakened, and then can

take food or answer questions. On the other hand, a complete inability to sleep may exist coupled with varying degrees of unrest, hyperactivity, and even delirium with transitory hallucinations or paranoid delusions. The clinical experiences of the great epidemic following the first world war as well as results of experimental investigations point to the existence of a sleep center localized in the posterior wall of the third ventricle, extending forward to the infundibular region and caudally to the aqueduct. Lethargic cases always show some oculomotor palsies.

Sleep disturbances may manifest themselves also in form of an inversion of the sleep rhythm, with hyperkinesis at night and deep sleep during daytime. Even an entire dissociation between the so-called "brainsleep" and "bodysleep" may develop. This presents the picture of a patient lying in bed during the day, completely akinetic, wide awake, yet unable to stand or move. At nightfall, he becomes agile and lively, bustling about and enjoying himself like a normal individual.

EYE DISTURBANCES

As to the disturbances of the ocular apparatus there may appear all kinds and all degrees of involvement of the oculomotor nerve, mostly bilateral: diplopia, strabismus, Argyll-Robertson pupil, paralysis of accomodation and convergence, nystagmus and ptosis. Most of these signs subside after the acute phase recedes, though the dilated pupil may never regain its light and accomodation reflex.

MOTOR DISTURBANCES

The polymorphism of the disease may create all variations and combinations of symptoms frequently occasioning diagnostic mistakes. Particularly treacherous is the myoclonic-choreatic syndrome which may appear in the earliest days of the sickness. It is usually combined with insomnia and with violent pains. These cases may be complicated by a delirious state that renders the diagnosis still more difficult. Involvement of the thalamus often leads to diagnostic error, especially when the intolerable pains, originating in the thalamus, are projected into the visceral organs. Unnecessary laparotomies have been performed in such cases.

Transitory mono-and hemiplegias, aphasias and disturbances of the vestibular system are rarer occurences. Sometimes the meninges more distinctly participate; only then will positive spinal fluid be noted.

PROGNOSIS

The more the vegetative centers are involved, the more conspicuous the hyperkinesis and delirious states, the worse the prognosis. Nor is outlook improved when the process spreads back to bulbo-pontine centers. Disturbances of breathing, swallowing and vasomotor involvement endanger life. The latter syndrome more and more assumes poliomyelitic features which are especially striking in some of the epidemics. Most patients, however, recover, though sequellae are to be expected.

DIAGNOSIS

Diagnosis is easily made in most cases, if the patient is subjected to a meticulous examination. Even misleading pains in distant organs can be correctly recognized as encephalitic symptoms because there will always be some signs which are inconsistent with an abdominal diagnosis. Perhaps the keystone of diagnosis is the doctor's awareness of the possibility of encephalitis.

726 West State Street

NEWARK BETH ISRAEL HOSPITAL CANCER CONFERENCE

April 3, 1946

MAX SINGER, M.D., Chairman

WILMS TUMORS

Presented by Dr. L. J. Levinson and Dr. N. J. Furst

Most embryonal sarcomas of the kidney are observed in infants and rarely are found after the tenth year. These tumors are characterized by a complex embryonic structure, rapid growth and fatal outcome.

In addition to the typical embryonal sarcomas, or Wilms tumors, there are also other renal neoplasms whose structures suggest a relationship to this group. Fibromyo-osteo sarcoma, fibro-lypomyoma, and myxo-liposarcoma have been described, and in all these renal epithelial elements are missing.

The first patient. J. G., a white male now nine years old, was born at the Newark Beth Israel Hospital on January 11, 1937; full term, weight was eight pounds thirteen ounces. On the third day following birth, the abdomen became distended. At the end of three weeks the abdomen was markedly enlarged with pronounced dilatation of the superficial veins. A large, firm mass was palpable on the left side extending to the mid-line from the costal margin to the iliac crest. X-ray examination revealed a retroperitoneal tumor. The left kidney failed to visualize. A preliminary diagnosis of Wilms tumor was made and the infant was referred to the Radiation Therapy Department for pre-operative Roentgen therapy.

After mild doses of high voltage x-ray therapy [totalling 600 and 800 roentgens] were administered to the anterior and posterior left abdomen, there was a perceptible decrease in the size of the tumor mass. On February 17, 1937, Dr. Sidney Keller operated on this five weeks old infant excising the left kidney and tumor mass. The mass was examined by Dr. Antopol and reported as Wilms tumor. The infant made an excellent recovery and is now, nine years later, normal in health and development.

DISCUSSION

DR. B. ROTHHOUSE: I cystoscoped this boy when he was seventeen days old. He was born with the mass in his kidney. The diagnosis was obvious. The tumor mass was removed through the regular kidney incision, extraperitoneally, without any difficulty. The patient now presents himself at the age of nine, a well developed, normal boy without any signs of recurrence. I think this is remarkable when one finds that ninety-five per cent of these cases of Wilms tumors die within one year as a result of widespread metastases.

The second patient, J. A., a three years old colored female was admitted on September 25, 1944. Her mother noticed that the child's abdomen was rapidly increasing in size. For the past two weeks there were clots of blood in the urine.

At the time of admission, the abdomen was markedly distended, a large firm mass was present on the right side filling the abdomen beyond the midline. Roentgen examination of the urinary tract failed to visualize the right kidney. The thorax was negative.

A preliminary diagnosis of Wilms tumor was established and pre-operative high voltage x-ray therapy was administered in an attempt to shrink the tumor mass. From September 14, 1944, to October 4, 1944, a total of 1000 roentgens was given the anterior and posterior right renal fields with slight effect on the tumor mass. On November 1, 1944, Dr. Comando performed a nephrectomy and Dr. L. Goldman confirmed the diagnosis of Wilms tumor on pathologic examination. Following the nephrectomy, post-operative roentgen therapy was administered, but the tumor recurred and the child died as a result of widespread metastases on April 5, 1945.

DISCUSSION

DR. H. COMANDO: This tumor was radio-resistant and unlike the usual Wilms tumor. A nephrectomy was performed through a trans-abdominal incision. The mass was extremely hard.

DR. L. LEVINSON: The first tumor was anaplastic and radio-sensitive. The second tumor was well differentiated, in some areas resembled a fibro-liposarcoma and was markedly radio-resistant.

CANCER OF THE TONGUE WITH NECK AND NODE METASTASIS

Presented by Dr. A. B. Abrams and Dr. L. J. Levinson

O. N., a white female, age 54, was first seen in May 1943. She complained of a lump in the right neck which had been present since September 1942. She had previously been a patient at the Eye and Ear Infirmary, where a lesion excised from the right lateral tongue margin was reported as epidermoid carcinoma, grade I.

Examination on May 14, 1943, showed a hard nodular mass at the angle of the right jaw measuring six centimeters in diameter, firm and fixed to the underlying structures. The right lateral portion of the tongue was hard and infiltrated. On May 15, high voltage x-ray treatments were initiated, directed to the right neck and tongue. A total of 3000 roentgens was administered in ten doses through a ten centimeter portal. The mass in the neck responded well to this treatment, but the tongue was still indurated at the completion of this therapy.

On June 25, 1943, under pentothal anesthesia, the neck node was exposed and seven gold needles, containing 46 milligrammes of radium, were inserted. In all, 2200 milligramme-hours were delivered. At the same time, ten smaller needles containing 33 milligrammes of radium were inserted into the tongue lesion and a dose of 1600 milligramme-hours was administered to this region. This treatment was followed by an intense radiation reaction in the neck and tongue. In May 1944 she returned with a node three centimeters in diameter in the left cervical region, opposite to the location of the primary lesion. High voltage x-ray therapy was administered to this area totalling 1800 roentgens. The patient did not then return until September. At that time the node was larger, measuring four centimeters in diameter, and was adherent to the surrounding structures. Interstitial radiation was again administered on September 25 when the node was exposed and eight gold needles were inserted. A dose of 2500 milligramme-hours was delivered.

Reaction to this treatment was very severe. She became progressively worse, losing weight and strength and suffering intense pain. Within the past six months, however, there has been marked improvement. The wound has healed and there is no pain. She has gained thirty pounds in weight since the reaction healed. On her last examination, January 24, 1946, there was no evidence of local recurrence.

DISCUSSION

DR. N. ZVAIFLER: The tongue is the one place where early diagnosis of cancer is easy. If the tongue is mobile and the lesion localized, surgery is the treatment of choice.

In the treatment of metastatic neck nodes, one must be drastic no matter what method is utilized. When surgery alone is used, radical neck node dissection is indicated. In this case, surgery was used primarily to facilitate interstitial radium therapy. Results are more satisfactory when the node can be exposed and properly visualized at the time of interstitial radium insertion.

NEOPLASM OF THE THYROID WITH LUNG METASTASIS

Presented by Dr. H. Comando

N. H., a female age 49, was admitted in November, 1942. Routine examination revealed nodular enlargement of the thyroid which extended below the sternum. The trachea was pushed to the left. Ten years prior to this admission, thyroidectomy had been performed at the St. Barnabas Hospital and the pathologic report was thyroid adenoma.

X-ray examination revealed numerous neoplastic areas of metastasis throughout the entire lung structure.

When this patient was presented at the Cancer Clinic Conference she had difficulty with breathing and swallowing. It was decided that palliative roentgen therapy would be administered and surgical intervention should be considered if dyspnea became more pronounced.

During 1942 and 1943, a total of 3000 roentgens was administered to the right and left thyroid areas and 1800 to each of eight thoracic fields. Her last treatment was February 4, 1944.

During the past two years her condition gradually improved. The masses in the neck have regressed until there is now only a slight residuum. The nodules in the lung have also regressed. She feels better, and has no difficulty with swallowing or breathing.

On several occasions, the patient was urged to have an excisional biopsy, but she refused.

DISCUSSION

Dr. W. Antopol: In 1925 Graham reported on the pronounced vascularity of the thyroid and said that in areas of adenomas of this organ, invasion of blood vessels was noted on careful microscopic examination.

In a large series, three per cent of these adenomas invaded blood vessels, and one out of ten showing blood vessel invasion metastasized to the lung. Papillary adenomas more frequently invade blood vessels These usually arise from lateral or aberrant thyroid tissue. These tumors are relatively benign. When they do metastasize to the lungs, they grow slowly and act as they would in tissue culture, not giving rise to secondary metastasis.

The patient presented by Dr. Comando has, in all likelihood, a tumor of the thyroid of this nature. The neoplasm invaded the blood vessels and metastasized to the lung. The tempo of tumor growth and metabolism being so slow, gives rise to minimal clinical manifestations only.

PLASMA CELL MYELOSIS

Presented by Dr. Lester Goldman

W. B., white male, age 73, reported that his present illness had begun in October 1944 with weakness, dyspnea and "feeling of faintness". In April 1945, he entered another hospital where he received blood transfusions and concentrated liver therapy. There was no material improvement and in October 1945 he entered the medical service of the Newark Beth Israel Hospital.

On admission, physical examination revealed marked pallor and a palpable liver. There was no evident lymphadenopathy or splenomegaly. Clinical impression was a malignant neoplasm or aplastic anemia. Laboratory findings at this time showed a red count of 2.7 million, hemoglobin 58 per cent and 5660 white cells. Only significant findings were: a positive cephalinflocculation test and a total serum protein of 9.4 milligrammes per cent. On the basis of the latter findings, a sternal marrow study was performed on November 6, 1945. This showed a characteristic picture of plasma-cell myelosis. Subsequent studies for presence of Bence-Jones' proteinuria and demonstrable bone changes on roentgenogram proved negative. The patient received repeated transfusions and was discharged on November 13, 1945, somewhat improved.

Intensive iron therapy proved of no value and it was decided to subject him to long bone x-ray therapy with the hope of overcoming marrow displacement by the anaplastic plasma-cell proliferation. Since the institution of this therapy, his blood picture has remained fairly constant, whereas, heretofore there was a persistent regression.

DISCUSSION

Dr. L. J. Levinson: This case shows the value of bone marrow studies in obscure cases of anemia.

The radiation therapy consisted of high voltage x-ray therapy totalling 25 roentgens to the entire trunk, abdomen, and extremities.

NEURO-FIBRO SARCOMA

Presented by Dr. William Kruger

M. B., a 16-year-old colored girl had had a slowly developing tumor on the dorsum of the right foot for four years. On July 5, 1944, she was admitted to the Beth Israel Hospital where Dr. William Ein excised a firm encapsulated tumor. Pathologic report was fibroma. She returned to the clinic in 1945 with an extensive recurrence on the dorsum of the foot. The mass was hard and infiltrating. She was referred to the Tumor Clinic for consultation. Another biopsy was recommended. Dr. Goldman's report was neuro-fibro sarcoma, and on February 13, 1946, an amputation of the right leg at the junction of the middle and upper third was performed.

X-ray examination of the chest was negative for metastasis at this time.

DISCUSSION

Dr. H. H. Kessler: These neuro-fibromas frequently recur, and with each recurrence become progressively more malignant.

NEWARK BETH ISRAEL HOSPITAL CANCER CONFERENCE

Cancer Committee

Dr. Max Singer, Chairman

Dr. W. Antopol	Dr. L. Goldman
Dr. A. Abrams	Dr. L. Levinson
Dr. H. Comando	Dr. N. Furst
Dr. W. Kruger	Dr. N. Zvaifler

201 Lyons Avenue

STATE ACTIVITIES

TRUSTEES MEETING

A regular meeting of the Board of Trustees was held at 1:00 p. m. Sunday, November 24, 1946, at the State Society Headquarters, Trenton.

Present were: Dr. Crowe, Chairman; who presided; Dr. Hawkes, Dr. Coleman, Dr. Costello, Dr. Green, Dr. Sica, Dr. Schaaf, Dr. Dodd, Dr. Johnsen, Dr. Alexander, Dr. Fithian, Dr. Lance, Dr. Lee, Dr. Norton, Dr. Stahl, and Dr. Scammell. Dr. Young was excused. Also present upon invitation were Dr. Allman, Dr. Davidson, Dr. Scott and Dr. Londrigan.

EXECUTIVE OFFICER

In accordance with the action of the Board on September 29, that "the matter of an Executive Officer for the State Society be laid over until another meeting of the Board of Trustees", this item was considered first by the Board.

After lengthy discussion by all members of the Board the following motions were adopted:

1. That the committee appointed to select the Veterans Liaison Officer be reappointed for the specific purpose of selecting candidates for the position of Executive Officer. (The Committee consists of Dr. Schaaf, Chairman, Dr. Alexander and Dr. Norton.)

2. That it be left to the discretion of the Committee as to whether a layman or physician be nominated for Executive Officer.

3. That it be the sense of the Board that an Executive Officer be employed on a full time basis.

4. That it be the sense of the Board that, when possible, in deference to the housing situation, it is desirable that the Executive Officer reside in or near Trenton.

5. That if a member of The Medical Society of New Jersey is selected he have the endorsement of his County Medical Society.

6. That it be the sense of this Board that it is desirable for the committee to explore the whole country in an effort to secure a competent man for the position.

7. That the Committee be instructed to draw up qualifications that they feel should apply to any Executive Officer that we appoint, and then that the committee make a survey of the available men, within and without the State, and present recommendations to the Board.

BOARD OF MEDICAL EXAMINERS

Dr. Green read a telegram from the Atlantic County Medical Society urging the nomination of Dr. David B. Allman for membership on the Board of Medical Examiners, to fill the vacancy caused by the death of Dr. Samuel Barbash.

Upon motion, seconded and unanimously carried it was directed that the following three names be submitted to the Governor for consideration in filling the vacancy on the Board of Medical Examiners.

Dr. David B. Allman, Atlantic City
Dr. Joseph F. Londrigan, Hoboken
Dr. James F. Norton, Jersey City

SCHOOL HEALTH PROGRAM

Dr. Green read the following communication from Dr. Samuel Blaugrund, Chairman of the Sub-Committee on Public Health:

The following are suggestions and recommendations from advisory committees for improving the health program in the public schools of New Jersey.

A. Legislative

1. Strip to the waist examinations.
2. Examinations on admission, the 4th grade, the 8th grade and the 12th grade.
3. Each county superintendent should be required to add a psychiatrist to the school system.
4. All school teachers and adult school personnel should be x-rayed for tuberculosis every year. (Every third year at present.)

B. Administrative

The school health committee be given authority to cooperate with the department of education of the State of New Jersey and other interested agencies to formulate aggressive health measures in the preventive pediatric field, and other measures conducive to better health in the school system.

Generally speaking, this would cover subjects such as: rheumatic fever, eye and ear defects, mental hygiene, crippled children, tuberculosis, standards for nursing and medical personnel, and the role of the family physician in school health administration.

C. Public Relations

The chairmen of the various sub-committees of the public health committee desire the privilege of releasing to the press their various activities and proposals.

Dr. Schaaf moved that these suggestions and recommendations be endorsed, and that the items pertaining to legislation be referred to the Sub-Committee on Legislation for action. Seconded by Dr. Fithian and unanimously carried.

CANCER CONTROL PROGRAM

Dr. Lee reported that the Advisory Committee on Cancer Control had considered a communication from the Mountainside Hospital in Montclair to the New Jersey Division of the American Cancer Society requesting $17,000 to operate a cancer clinic in that hospital for one year. Dr. Lee explained that the policy of the American Cancer Society is that any project be cleared through the local county chapter and the County Medical Society, which has not been done in this case. The communication also requested $25,000 for the development of the existing tumor clinic at the Mountainside Hospital. The Advisory Committee on Cancer Control recommends that the request for $17,000 for a cancer clinic be disapproved, but that approval be given to the request for $25,000 to expand the existing tumor clinic, if endorsement is obtained from the local county chapter and the Essex County Medical Society.

Dr. Lee moved that the recommendations of the Cancer Committee be concurred in. Seconded and unanimously carried.

OBSTETRICAL PROCEDURES

Dr. Norton read the contents of a proposed placard, "Procedure: Obstetrical Department", prepared by the Advisory Committee on Maternal Welfare for distribution to the hospitals in New Jersey.

Dr. Norton moved that the placard be approved and that a copy be sent to each hospital with the request that it be studied and, if approved, posted in the obstetrical department of the hospital. Seconded by Dr. Lee and unanimously carried.

FINANCE AND BUDGET COMMITTEE

Dr. Allman, Chairman of the Finance and Budget Committee, presented the following recommendations from that Committee. On motion, all these recommendations were concurred in.

1. That the Committee be authorized to transfer the unexpended budget appropriated for the permanent home, apartment rental, and any other refunds in connection with the Home carrying charges, to the House Committee Reserve Account at the close of the 1945-46 fiscal year and at the close of each future fiscal year.

2. That a contribution of $150 be forwarded to the Middle Atlantic State Regional Conference.

3. That the 1939 Buick owned by The Medical Society of New Jersey be traded in and a new car purchased.

4. Dr. Allman stated that the Finance Committee had abided by the ruling of the Board to pay A.M.A. Delegates first class fare, lower berth, and $12 per day expenses while attending an A.M.A. meeting. However, several of the delegates' expenses exceeded the amount authorized by the Board, and the Finance Committee recommends that these Delegates be reimbursed for the balance of their expenses.

5. That the $1000 being paid to Mrs. Edith L. Madden as Acting Executive Officer be made a part of her permanent salary.

6. That the office employees of The Medical Society of New Jersey be given a Christmas gift of one week's salary.

7. That the Treasurer be empowered to sell a bond of the Investors Mortgage and Realty Company and shares in the Trenton Mortgage Service Company when it seems feasible to do so.

Dr. Allman called to the attention of the Trustees the fact that $3900 per year was being spent for releases of the Public Relations Committee to newspapers and industrial house organs. There are 268 newspapers and 80 house organs being circularized. About 57 newspapers and 22 house organs are using the material.

Dr. Norton moved that the matter of expenditure for news releases be referred to the Committee appointed to secure an Executive Officer. Seconded by Dr. Schaaf and unanimously carried.

Dr. Allman asked if the State Society were planning to contribute toward the cost of the dinner given to the A.M.A. Delegates at the time of the meeting in Atlantic City in June; and also if any contributions were to be made to the Woman's Auxiliary in connection with the A.M.A. meeting.

Dr. Alexander moved that $800 be made available for the Woman's Auxiliary, and that the matter of the dinner to the A.M.A. Delegates be considered later. Seconded by Dr. Costello and unanimously carried.

AUDIT REPORT

Dr. Costello presented the following report of the Audit Committee:

The Committee has examined the financial statements and auditors reports for the year ending May 31, 1946. To the best of their knowledge and belief this represents a true picture of receipts and disbursements of the funds for that period.

Dr. Lance moved that the report be received. Seconded by Dr. Alexander and unanimously carried.

INSURANCE COMMITTEE

Dr. Costello presented the following report of the Insurance Committee:

Your Committee met with the State Committee on Medical Defense and Insurance on November 6th at the Academy of Medicine with Dr. J. W. Hurff, acting as Chairman due to the illness of Dr. C. C. Beling.

After an extensive review of all phases of the case it is the unanimous opinion of your Committee that the advice of the Insurance Company's Attorneys was to the best interest of the defendant physician, namely, that the case be settled out of court.

The following is quoted from the contract:

"No claim covered by this policy shall be settled or compromised by the Company without the consent of the Assured. If the Assured is in doubt as to the advisability of compromising such a claim brought against him, he shall have the privilege of submitting the matter to a committee of members of the Medical Society of the State of New Jersey, one to be selected by himself, one to be selected by the Company, and three to be selected by the Insurance Committee of the Medical Society of the State of New Jersey. The facts of the case shall be presented to this committee whose decision is for the guidance of the Assured against whom claim has been brought, it being understood and agreed that his right to make the final decision is not hereby surrendered or relinquished."

We do not find that this procedure was followed.

As a result of our conference we would recommend that certain definite suggestions be made to the State Insurance Committee in the conduct of its activities.

1. In all controversial cases stenographic records of the meetings be kept and filed.

2. In its deliberations with the Company all actions taken shall have the concurrence and approval of at least three members of that Committee. Since members of the Committee came from various parts of the State, the meetings have been poorly attended and much of this work has been done by the Chairman. We suggest that meetings be held at our headquarters in Trenton which is centrally located; stenographic service is available and proper depository for records is at hand.

3. In reference to cancellation of contracts we find that, since the contract has been in force, the contracts of 21 of our members have been cancelled or not renewed. Of the 21 members, twelve made an appeal to the State Committee for redress. The State Committee, after conference with the Insurance Company, was successful in having the contracts of 11 members renewed and, in the case of the remaining physician, the Committee concurred with the Insurance Company that the Contract should not be renewed. The other 9 men made no effort to have their contracts renewed. In this connection your Committee recommends that we suggest to our State Committee that they negotiate with the Insurance Company to the end that no contract will be cancelled until after conference between the Insurance Company and the Committee rather than having appeal taken after cancellation.

There has been a thought advanced that the minimum limit of insurance coverage should be raised. This is a matter that will need discussion between the Company and our Committee as it would mean an amendment to the present contract. Your Committee does not feel that this question falls within the scope of the purpose for which it was appointed.

Dr. Schaaf moved that the report and recommendations be approved. Seconded and unanimously carried.

Dr. Schaaf moved that the Insurance Committee be asked to negotiate with the U. S. Fidelity and Guarantee Company to have the insurance of the defendant physician in this recent malpractice case reinstated in the full amount. Seconded by Dr. Norton and unanimously carried.

COMMITTEE ON OSTEOPATHIC RELATIONS

Dr. Johnsen, Chairman of the Committee on Osteopathic Relations, presented the following resolution and recommendation from his committee:

Resolved that it shall not be considered unethical on the part of any member of The Medical Society of New Jersey to consult with any one who possesses a full license to practice medicine and surgery in New Jersey.

The special committee on Osteopathic Relations recommends that the Board of Trustees of The Medical Society of New Jersey request the State Board of Medical Examiners to apply to the Council on Medical Education for an inspection of the Philadelphia College of Osteopathy and the Los Angeles College of Osteopathy.

Dr. Johnsen moved that the above resolution be adopted and the recommendation approved. Seconded and unanimously carried.

VETERANS LIAISON COMMITTEE

Dr. Londrigan, Chairman of the Veterans Liaison Committee, gave a detailed report of the activities of the Committee since the last meeting of this Board, which is on file in the Executive Offices. Dr. Londrigan's report stated that the Monmouth and Hudson Plans have been signed and authorizations have already been given to these two plans. The Monmouth Plan is in operation and the Hudson Plan will begin operation on December 3rd.

RESOLUTIONS ON THE DEATH OF DR. EAGLETON

Dr. Green read resolutions on the death of Dr. Wells P. Eagleton, prepared by the committee appointed for that purpose:

WELLS PHILLIPS EAGLETON
1865 - 1946

On September eleventh, 1946, The Medical Society of New Jersey suffered the loss of its Senior Fellow, Wells Phillips Eagleton. On that day, not only the doctors of this state, but all of its citizens, the high and the lowly, lost a man who labored assiduously and gloriously in their behalf. The activities of Dr. Eagleton adorned a vast canvas. As a surgeon he was a credit to his profession and to his country; as an administrator, a potent leader of many medical and civic organizations; as a man, a kindly and affectionate friend to all who were privileged to be near him; and as a citizen he was a valiant captain of the forces of human progress. His achievements and his honors have been recorded elsewhere: in the annals of American medicine, in the columns of Who's Who, in obituaries in many medical periodicals, and in the editorials of the newspapers. They need not be repeated here, for the activities and accomplishments of Dr. Eagleton are firmly enshrined in the minds and memories of all who knew him.

BE IT RESOLVED that this memorial of the esteem in which we, the Officers and members of The Medical Society of New Jersey, held Dr. Eagleton, and this token of the affectionate place he has won in the hearts of the profession and people of this state, be spread upon the records of the Society, published in its JOURNAL and transmitted to his bereaved family.

It was regularly moved, seconded and unanimously carried, that the above resolutions be adopted and a copy forwarded to the family of Dr. Eagleton.

RESOLUTIONS ON THE DEATH OF DR. NORTH

It was directed that the Chairman of the committee to draw up resolutions on the death of Dr. North be requested to have these resolutions prepared at the earliest possible moment and forwarded to the family of Dr. North; approval of these resolutions by the Board to be obtained at its next meeting.

PRESIDENT SCAMMELL

President Scammell thanked Dr. Schaaf and the members of the Board for their cooperation and assistance during his illness, and asked that Dr. Schaaf continue to carry on as Acting President.

REPORT OF ACTING PRESIDENT

Dr. Schaaf reported that he had attended the meeting of the Middle Atlantic States Regional Conference in Philadelphia on November 21st. (Dr. Scott subsequently gave a brief report on the Conference which is published on page 17 of this JOURNAL.

Dr. Schaaf stated that a meeting had been held in Newark on November 19 with officers and committee chairmen of the Society to discuss proposals, which it is planned will be presented to Governor-Elect Driscoll in connection with his contemplated health program for the State.

Dr. Schaaf stated he had received a letter from Bishop Eustace of Camden asking endorsement of a proposal of the Diocese of Camden to erect a 292 bed general hospital in Camden and a 23 bed children's hospital between Atlantic City and Cape May. Dr. Schaaf replied to this communication stating he felt the Medical Society would be glad to endorse the project.

Upon motion, seconded and unanimously carried, Dr. Schaaf's action in replying to Bishop Eustace was approved and it was directed that a communication be forwarded to the Bishop gaving official approval from the Society.

Dr. Schaaf stated that he understood that the Legislature would be asked to appropriate $13,000,000 for expansion of Rutgers University, and felt that it was an opportune time for additional monies to be requested for the purpose of establishing a medical school under the auspices of Rutgers University. Dr. Schaaf offered the following resolution:

Hereby resolved that The Medical Society of New Jersey endorses the principle of an approved medical school under university auspices, supported by adequate funds secured by state appropriation.

Dr. Alexander moved that the above resolution be approved. Seconded by Dr. Norton and unanimously carried.

MEDICAL SERVICE ADMINISTRATION—MEDICAL-SURGICAL PLAN

Dr. Scott presented a report on Medical-Surgical Plan, the Veterans Medical Care Plan, the City of Newark Medical Plan and the Farm Security Medical Plan, and offered the following recommendation and motion from the Board of Trustees of Medical Service Administration.

Whereas there has been a marked reduction in the percentage of enrollment in the Farm Security Plan which resulted in an increased sick rate which the present income of the Plan cannot meet, it is recommended to the Board of Trustees of The Medical Society of New Jersey that the present Plan be discontinued and that steps be taken with Farm Security Administration to develop a Plan of full coverage to include home, office, hospital care and the cost of hospitalization for this group.

Medical Service Administration approved the recommendations evolved by a group which met at the Essex Club on November 19, 1946, to the effect that the State of New Jersey through New Jersey Municipal Aid Administration recognize the category of single phase medical indigency, with the understanding that a community agency rather than the medical profession determine eligibility of a person or family for recognition and medical care under this category.

Upon motion by Dr. Johnsen, seconded and unanimously carried, this resolution and motion were approved.

COMMUNICATION

Dr. Schaaf presented a communication from Dr. Daniel Bergsma, Deputy Director of Health of New Jersey, relative to the transfer of certain essential health programs to the State budget. At the present time certain divisions of the Health Department are supported by Federal funds, either in whole or in part.

Dr. Schaaf moved that the communication be referred to the Public Health Committee for opinion, and that an early report be requested. Seconded and unanimously carried.

Upon motion the meeting was adjourned at 4:40 p. m.

DAVID W. GREEN, M.D.,
Secretary.

CITATIONS TO NEW JERSEY DOCTORS—Additional Names

On page 506 of the December, 1946 JOURNAL appeared a preliminary list of military and naval citations to New Jersey physicians. Announcement is made of the following additional names, about which the Editorial Office has just been informed:

COLLINS, Louis K., Glassboro . . Distinguished Flying Cross
COPLEMAN, Hyman B., New Brunswick . . . Silver Star with Cluster
CRICCO, Carl F., Hoboken . . . . . Bronze Star
CRUNDEN, Allan B., Montclair . . Legion of Merit
EVANS, J. Lawrence, Jr., Leonia . . . . Bronze Star
GROSSBLATT, Philip, Newark . . Army Commendation Ribbon
GUIDOTTA, Frank P., Trenton . . . Legion of Merit
JACOBS, William, Irvington . . . . . Bronze Star and Purple Heart with Oak Leaf Cluster
KOSMINSKY, Louis, West New York . . . . . Bronze Star with Cluster
LEVINSON, Reuben, Perth Amboy . . Divisional Commendation
McLANE, A. Donald, Englewood . . Legion of Merit

NEW FORMULARY NOW AVAILABLE

National Formulary VIII which becomes official in April of this year, is now available and may be purchased directly from the Mack Publishing Company, 20th and Northampton Streets, Easton, Pa., at $7.50 a copy.

PROPOSED AMENDMENT TO THE CONSTITUTION

The following proposed amendment to the Constitution was approved by the House of Delegates at the 1946 Annual Meeting and will be presented for final approval at the meeting in April, 1947. The proposed amendment is herewith published in full in compliance with the constitutional provision to that effect. The italicized phrases represent proposed additions to Section 5 of Article IV of the Constitution.

"Honorary members shall be physicians and surgeons who have attained distinction within the medical profession, *or nonmedical persons who have rendered signal service to The Medical Society of New Jersey or who have attained special eminence in scientific fields other than medicine,* and who may be elected by a two-thirds vote of the House of Delegates after having been recommended by the Committee on Honorary Membership; provided the number of living Honorary Members does not exceed fifteen They shall have all the privileges of members but shall not be members of the corporate body."

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Chairman, Nutrition Committee

1. *To switch from regular insulin to protamine zinc insulin, what proportion should I use?*

   In old patients on regular insulin, use one fourth as much protamine zinc insulin.

2. *If a patient is allergic to milk what are the next richest sources of calcium which she can use?*

   Green leafy vegetables such as mustard greens, chard, collards, spinach and kale; turnip tops, radish tops, beet tops, soy beans and maple syrup.

3. *A girl 19 years of age, weighing 182 pounds with a very oily skin, particularly of the face, has been on numerous reducing diets since age 14. She has had all sorts of beauty treatments. Many dermatologists have prescribed for her. Does this sound like nutritional imbalance?*

   Her diets were probably inadequate and did not contain enough of the glandular meats. She should have a diet rich in liver, sweetbreads, eggs and beef; also one quart of skim milk a day. Give one tablespoon of powdered yeast in water after meals, riboflavin in ten to thirty milligram doses should be given with the B Complex. This seems to be a riboflavin deficiency.

4. *Is desoxyephedrine as good as amphetamine for obesity?*

   Neither causes loss of body fat. Amphetamine produces a feeling of well being in many patients while desoxyephedrine does not bring about much emotional stimulation. Amphetamine inhibits the appetite in about 40 per cent; desoxy has little or no effect on the appetite. However, side effects of both drugs are about the same namely,—dryness of the mouth, palpitation, halitosis, insomnia, muscular pain, headaches, weakness, dizziness and nervousness.

5. *What are the symptoms of overdosage with Vitamin D?*

   Headache, nausea, loss of appetite and diarrhea. The blood and urine shows excessive amounts of calcium and phosphorous.

6. *Do frozen foods retain their vitamin content?*

   Yes. But the vitamin loss starts as soon as the food begins to thaw out. Hence food should be served soon after taking it out of the refrigerator. The longer the thawing out period, the greater the loss.

7. *Does sugar cause cavities in teeth?*

   No. Sugar will promote the enlargement of cavities but fails to cause their initial appearance.

8. *Some people feel the cold weather more than others in winter. Will certain foods increase tolerance to cold?*

   Yes. Increase the carbohydrates in the diet and this will enable the person to withstand cold weather more comfortably.

REGIONAL MEETING OF THE COUNCIL ON MEDICAL SERVICE

Norman M. Scott, M.D.

This report covers the three main topics reviewed at the meeting (1) The medical aspects of the bituminous coal miners' agreement, (2) Outpatient veterans care, and (3) The Taft-Smith-Ball bill.

The program of the Council on Medical Services of the A. M. A. includes regional meetings with the state society representatives. We are in a region which includes New York, New Jersey, Pennsylvania, Maryland, Delaware, Virginia and the District of Columbia. Representatives of these states met with representatives of the Council in Philadelphia on November 21, 1946. Those from New Jersey were: Doctors Schaaf, Alexander, Crowe, Pollak, Read, Quigley and Scott.

Because of the importance attached to the United Mine Workers Medical Care Plan in the bituminous coal region, representatives of West Virginia and Ohio were also present.

The Conference approved the decision of the Executive Committee that consideration of the Mine Workers Medical Care Plan situation came within the jurisdiction of the Council on Medical Service rather than the Council on Industrial Health.

THE BITUMINOUS COAL MINERS AGREEMENT

This subject was presented by Dr. Walter Martin of Virginia. He explained that the Mine Workers contract provides for both a welfare fund and a health fund.

The Welfare Fund is financed by a donation of five cents on each ton of coal mined, administered by a board of three members, one selected by the workers, one by the owners and a third chosen by these two. It is estimated that the fund will amount to about 30 million dollars a year. To date the funds are held by a government custodian. No administrative board has yet been selected, and it is contemplated that no definite action will be taken in this regard until the mines are freed from government control and returned to their owners.

The Health Fund is to be financed by money raised by a "check-off" system on miners' wages and to be operated by representatives of the workers. It will provide for complete medical, dental and hospital care of union members and their dependents. To date this plan is not in operation.

The mine physicians have organized a society to assist in a solution of the problem and guard the interests of the physicians involved. Special survey teams of members of the Navy Medical Corps are surveying the health problems of the entire coal mining region.

At a conference held in Washington on October 30, 1946, between the Mine Physicians' Association and the Navy Survey Committee, these points were brought out:

1. Certain abuses of the contract practice now in operation justify some of the grievances of the workers.
2. Physicians selected by the owners sometimes have a primary interest in the welfare of the owners rather than the workers.
3. In the system of pre-employment examinations, workers are denied privacy of records.
4. Compensation insurance not well administered because of prejudice of examining physicians in favor of owners.
5. Medical service and hospitalization is spotty, being excellent in some places, poor in others.

It is generally felt that continuation of contract practice under jurisdiction of the mine workers would not solve the problem. A proper solution can be reached only by a cooperative plan jointly controlled by physicians, owners and mine workers. It should be integrated with other community services and administered by a neutral third party.

Dr. Palmer of Pennsylvania said that their agreement is similar to that in the other states, but procedures and details are still not determined. He believes that where the service is not adequate it is due to the personality and training of the physician and to restrictions placed upon physicians by the owners.

The present agreement represents a new economic philosophy. It places an additional cost on the coal used by the general population for the benefit of a specific group.

He feels that organized medicine should cooperate in developing a high type of medical service in the mining regions and that the administrative board should include representatives of the miners, the public, medical profession and hospital administrators. We must clear up areas where conditions are bad. This program cannot be developed until there is real cooperation between management and labor.

Dr. Rogers of West Virginia pointed out that there are 100,000 miners in the soft coal industry. Fully 90 per cent of them receive medical care through a system of contract practice which has been in operation for fifty years.

The service is rendered at two levels: (1) Mining camp; (2) In Hospitals. To pay for the service each miner is assessed by payroll deduction each month; this money is paid directly to the physician.

At the mining camp level, the services are those of a general practitioner, who renders general medical care and attention to minor injuries and who is usually allowed to make additional charges for obstetrical and venereal disease cases. These physicians are selected by the owners.

At the hospital level, costs are defrayed by monthly assessments on miners' pay, payable directly to the hospitals. The owner has no connection with the hospital, except for collection and payment of funds. The institutions provide hospitalization and the services of a professional staff. The staff is sometimes complete, particularly in larger hospitals; in smaller hospitals it is usually incomplete.

The entire program is in many instances excellent, in others mediocre or poor at both levels.

Many physicians are leaving the field and few replacements are available. In many areas, one physician is doing the work of three.

We are not concerned with the Welfare Fund any more than is the general population. We are definitely concerned with the Health Fund.

Proper conduct of the plan requires good business administration and good medical administration which is not now available among mine workers. If administered by the workers it would probably be on a per capita basis, which would not solve the problem. It would mean no free choice of physician and much unnecessary work on the part of physicians. Alternatives would be:

1. A blanket contract with an insurance company. Objection to this is the cost; also it could probably include only surgery or catastrophic illnesses.
2. A plan evolved through the cooperation of the Blue Cross and a nonprofit medical service plan. The miners would probably object to this because of costs.
3. The mine operators might administer the fund themselves on a fee for service basis. This would also be subject to abuse.

Dr. Long of Pennsylvania Industrial Commission advised watchful waiting. The conditions in Pennsylvania are similar to those described as to West Virginia. He felt that nothing would be done to implement the program in Pennsylvania until the government releases the mines. He hopes that then the mine workers union will operate the plan on a basis of free choice of physician.

Dr. Ederly from the Association of Mine Physicians warned that this is a back-door for socialized medicine, and that other unions will follow this example. For their small contribution, said Dr. Ederly, the miners demand a large amount of service. And if we don't give them what they want, they will then demand government medicine. Dr. Ederly estimated that the average miner earned $15 a day and was thus financially capable of paying for adequate medical care. If they pay enough, he said, they will get it. At present, explained Dr. Ederly, they get cheap service because that is what the union leaders demand. The average miner would be willing to pay for good service if allowed to do so by his leaders. Attention was called to the fact that the miner pays about $48 a year per family, for complete medical care and hospital costs, whereas average cost in the general population is about $70. They now want more for less.

Dr. Martin remarked that the situation is now in a state of flux. No doubt there are many instances of poor medical care, poor sanitation and poor hospital facilities.

Our responsibility is to offer our services in evolving an adequate program and to see that the program is properly integrated with community services and not a special privilege for the benefit of a special group. It should include proper sanitation and milk supply. The profession is the only agency that can promulgate a full program.

VETERANS ADMINISTRATION

Dr. Harding reviewed the problem of outpatient care of veterans.

There are four million veterans of previous wars and sixteen million veterans of World War II eligible for this service. Plans adopted by the state societies are of two types:

1. The administrative details and payment of physicians are handled by V. A. in accordance with fees mutually agreed upon.
2. The Plan is administered through an intermediary agency, such as a medical service plan organization.

New York and New Jersey have a variation of Type 1 in that they use medical coordinators stationed in the V. A. office.

V. A. clinics and examination centers will be expanded, but in spite of this expansion, V. A. cannot handle the entire load. Their clinics must be augmented by medical society agreements to meet the load.

Physical examination of veterans to determine pension benefits presents a special problem. The adjudication agency within V. A. composed of laymen with medical advisers must determine the amount of pension and disability, based on reports received by physicians. These reports must indicate the degree or ex-

tent of disability, not in terms of percentage or dollars, but by a complete description of the disability, to include such information as the degree of limitation of an injured point.

Out-patient treatments are covered only if they pertain to service connected disabilities. This has caused some dissatisfaction and confusion through misunderstanding by physicians, but there is nothing V. A. can do about it. That is the law.

Arrangements have been made through most state pharmaceutical societies for filling of prescriptions by member drug stores. Frequently a physician will write several prescriptions, some of which are not applicable to a service connected disability. If these are filled, V. A. must refuse to reimburse the pharmacist. Limit your prescriptions to those necessary in the treatment of service connected disabilities.

THE TAFT-SMITH-BALL BILL

This subject was presented by Dr. Frederic J. Quigley as moderator and discussed by Dr. Louis Bauer, representing the Council.

Main controversy evolved during the discussion centered around the principle of federal grants in aid, in accordance with a variable formula, to states with sufficient income to support their program without federal aid. This, it was pointed out, conflicted with item 7 of the platform of the A.M.A. which approves of federal aid to states when the need is demonstrated. It was pointed out that the percentage of the total cost, to a prosperous state, would be so small that it would probably be to the disadvantage of such a state to accept the grant and be limited in the administration of its program in accordance with policies promulgated by the federal government. The possibility was suggested that federal aid might be limited to the several southern states where per capita income is obviously insufficient to support an adequate program without federal aid.

NATIONAL CONFERENCE ON MEDICAL SERVICE

The 20th Annual Meeting of the National Conference on Medical Service will be held at the Palmer House in Chicago on February 9. Registration will begin at 9:00 a. m., and the program will include discussions in the fields of national affairs, economics and medical education. All physicians are invited to attend. There is no registration fee. Dr. Cleon A. Nafe, Indianapolis, is president of the Conference and Dr. Creighton Barker, New Haven, is the secretary.

ASSOCIATES AVAILABLE

Any physician wishing an association with a New Jersey practitioner is welcome to place a notice of reasonable length in this column without charge. Any reader interested in establishing contact with any of these doctors, should write to The Medical Society of New Jersey at 315 West State Street, Trenton 8, Please indicate the notice number.

WELL-TRAINED FORMER ARMY OFFICER desires association with established internist or an industrial appointment. Prefers northern New Jersey. Refer to notice 47-1.

ASSOCIATE OR ASSISTANT AVAILABLE TO GENERAL PRACTITIONER in any part of New Jersey. Licensed in New Jersey. Veteran with five years rich and varied medical activities in army. Refer to notice 47-2.

OTOLARYNGOLOGIST available for association with EENT man in Northern New Jersey. Age 31, ready to take boards. Refer to notice 47-3.

INTERNIST OR PSYCHIATRIST needing associate may have services of physician with wide experience in both specialties. Excellent references and record. Refer to notice 47-4.

MATURE GENERAL PRACTITIONER now available as part-time associate for internist, dermatologist or obstetrician in northern New Jersey. Refer to notice 47-5.

SOUTHERN NEW JERSEY: GENERAL PRACTITIONER, long experience in medicine, available to internist, pediatrician, obstetrician or medical group. Refer to notice 47-6.

OBSTETRICIAN-GYNECOLOGIST, FULL BOARD DIPLOMATE, age 33, available for association, full-time or part-time, with established specialist or with group. Refer to notice 47-7.

BOARD-ELIGIBLE RADIOLOGIST with rich experience in therapeutic and diagnostic roentgenology available for association with individual, hospital or group. Refer to notice 47-8.

MEDICAL-SURGICAL PLAN

A REPORT TO THE PROFESSION

As of November 30, 1946, there were 84,931 persons enrolled under the Plan's Subscription Contract. And 3,297 additional persons were enrolled under subscription contracts with future effective dates, making a total of 88,228 persons. The earned income (subscription income) for November was $57,815, an average of 68 cents per person. Average number of persons per contract was 2.2.

For the eleven months ending November 30, 1946, total earned income was $480,338. Incidence of treatment was at the rate of 86 per 1,000 persons per year. Operating costs were 17 per cent of earned income and reserves totaled 13.8 per cent of earned income.

Income per person and number of persons per contract remains constant. The incidence of persons treated fluctuates. It is lower in groups with a high ratio of enrollment than in those groups with low proportions of enrollment; it is low during the winter holiday season and high during the spring and early summer months.

While during the past year there have been no appreciable increases in the amounts payable under our schedule of benefits, there has been an expansion of our scope of eligible services, to include payment of benefits for (1) tonsillectomies performed in physicians' offices, (2) obstetrical care rendered outside of hospital at time of full term delivery, (3) operative procedures in the outpatient departments of hospitals without admisson of patient as a bed patient, and (4) emergency surgical care occasioned by accidental injury rendered anywhere within 24 hours of the accident. The cost to the Plan for these additional services is reflected in the reduction in the percentage of reserves accumulated during paralleling periods of 1945 and 1946. Our reserves during the same period of 1945 totaled 16.1 per cent of income as compared to 13.8 per cent this year.

The only way by which the amounts payable for physicians' services, under our present subscription rate, can be increased is by raising the proportions of enrollments in groups. The higher the percentage of enrollment, the better the cross section of health in the groups, the lower the incidence of illness and the higher the average amount of money available per illness for payment of physicians' services. Participating physicians may aid in accomplishing this by their cooperation in carrying out the contract provisions, thus making the Plan more attractive to such groups. They can help reduce administrative costs by adhering to the administrative procedure outlined below.

Voluntary medical service plans are the only alternative yet evolved for compulsory sickness insurance. The sword of federal control, through compulsory sickness insurance, will hang over the profession until the physicians of this country develop these plans to meet the needs of the people.

ADMINISTRATIVE PROCEDURES

Efficient and economical administration of the Plan requires adherence to routine administrative procedures. These procedures are integrated with certain administrative precedures of Hospital Service Plan of New Jersey, although there is no organic connection between the two Plans. They are separate corporations.

Each of our subscribers is also a subscriber to Hospital Service Plan of New Jersey.

NOTICE OF HOSPITALIZED CASES

When a subscriber or enrolled dependent is admitted to hospital as a bed-patient, the institution submits to Hospital Service Plan of New Jersey a "notice of Hospital Admission". Medical-Surgical Plan is furnished with a transcript of this notice which includes the name of the admitting physician, to whom we forward a copy of our "Physician's Statement" upon which the attending physician submits his bill to Medical-Surgical Plan.

Physicians are requested to recognize this procedure, rather than to submit their bills on their own personal bill-heads.

If the physician has not received a copy of our "Physician's Statement" after ten days following discharge of patient from hospital, he should telephone or write Medical-Surgical Plan giving the name of the subscriber, (name of patient, if different), name of hospital and date of admission, (and if possible the contract number of the subscriber).

EMERGENCY CASES

Regarding cases rendered eligible emergency surgical care in *out-patient departments,* or *emergency surgical care occasioned by accidental injuries* rendered anywhere within 24 hours of the accident, a "notice of hospitalization" for out-patient care is not submitted. In such cases, the physician should bill Medical-Surgical Plan direct, giving name of subscriber, (name of patient, if different), date and place of service, diagnosis, operative procedure and contract number. The physician may request a copy of Physician's Statement upon which to present the information and amount of the bill.

PAYMENTS TO PHYSICIANS

Medical-Surgical Plan mails benefit checks on the 14th and 28th day of each month.

The Physician's Statement (see illustration) is completed as far as possible in the Plan's office before mailing to the physician. An addressed pre-paid return envelope is enclosed for convenience. Please return it promptly.

In surgical cases, please submit the type of operation, date of operation, and date of discharge from hospital.

In medical cases indicate by check mark on calendar the date of each professional hospital visit.

If physician anesthetist or consultant was used, submit his name and address.

In submitting bill, please set forth the amount that would have been billed the patient, even though the Medical-Surgical Plan schedule may not always provide payment of the full amount of the bill.

SCHEDULE OF BENEFITS

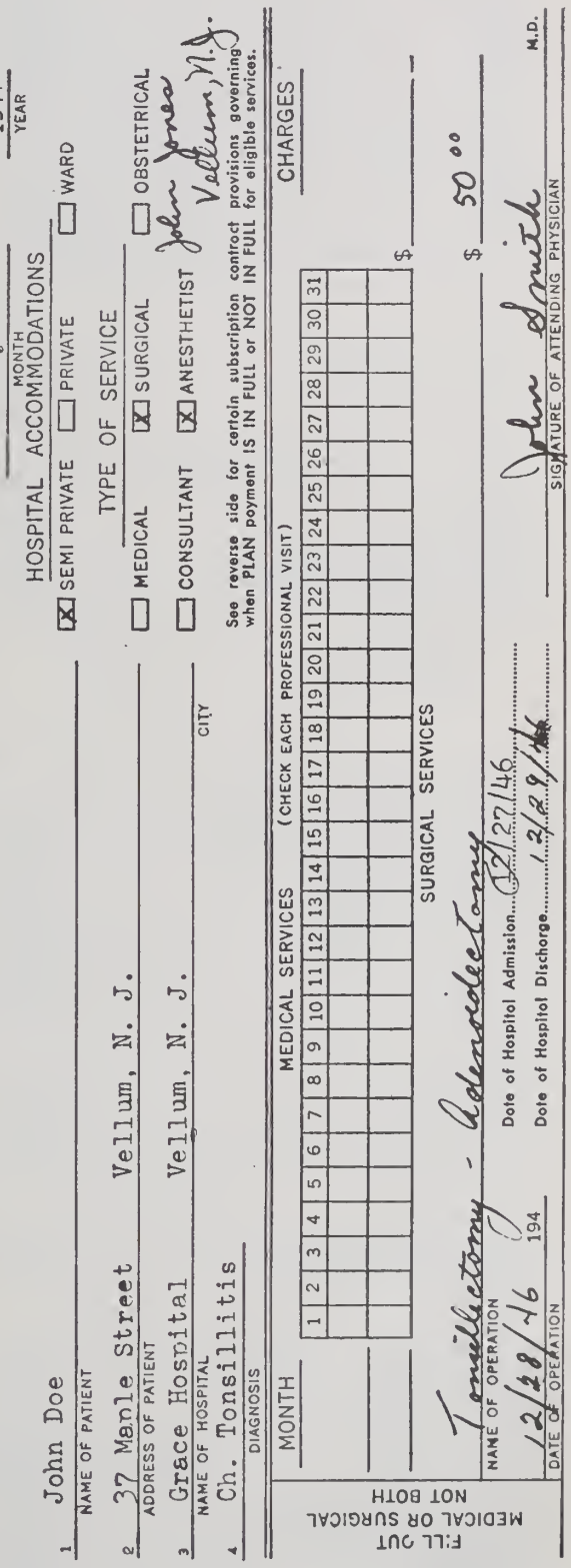
The following excerpts from the currently complete schedule of benefits represent some of the more frequently used items. Amounts payable by the Plan not included here may be obtained upon inquiry. They are generally consistent in amount with those illustrated below.

Except as hereinafter indicated participating physcians accept the payments of the Plan in full for eligible services providing the patient is admitted for ward or semi-private accommodations in an approved hospital. The exceptions to the foregoing are:

1. If the patient is admitted for, or transfers to, a private accommodation of one bed per room (unless transferred at the instance of the physician or hospital).

2. If the patient, admitted for a semi-private or ward accommodation, agrees to pay

PHYSICIAN'S STATEMENT



the participating physician a sum additional to the amount payable by the Plan, or fails to disclose that he is enrolled under the contract. However, no such agreement for additional payment may be made if, for the twelve calendar months immediately preceding the month in which hospital admission occurs, the income of the subscriber under a Single Contract is less than $2,000; or the income of the subscriber under a Family Contract is less than $2,000, plus $500 for the first enrolled dependent (wife [husband] or child) plus $250 for each additional enrolled dependent.

MEDICAL

Initial Hospital Visit	$ 5.00
Subsequent Daily Visits	3.00

ANESTHESIA, CONSULTATIONS, BLOOD TRANSFUSIONS

Consultation	$ 10.00
Anesthesia, general or spinal	10.00
Anesthesia, intra-tracheal	25.00
Anesthesia, caudal, obstetrical	25.00
Intravenous Plasma or Serum	10.00
Blood Tranfusion, each	25.00

If administered by a private physician. Limited to two during any one period of hospitalization.

SURGICAL

Surgery of Superficial Tissues

Inc. and dr. superficial abscess	$ 10.00
Inc. and dr. deep abscess	25.00
Inc. and dr. deep cervical infection	50.00
Repair, minor injuries	10.00
Repair, multiple minor injuries	25.00
Exc. sebaceous cyst	10.00
multiple	20.00
Exc. pilonidal cyst	50.00
Exc. ganglion	35.00
Exc. wide, epithelioma	50.00

Thyroid and Breast

Thyroidectomy	$125.00
Exc. non mal. breast tumor	50.00
Inc. and dr. breast abscess	25.00
Mastectomy, radical	100.00

Varicose Veins

Saphenous ligation, high	$ 50.00
Saphenous ligation, bilateral	75.00

Abdominal

Laparotomy	$100.00
Hernia, inguinal or femoral	75.00
Hernia, recurrent or ventral	100.00
Hernia, strangulated	125.00
Hernia, bilateral	100.00
Gastro-enterostomy	150.00
Gastric resection	150.00
Peptic ulcer perf. closure	125.00
Intestinal or colon resection	150.00
Diverticulum, resection	150.00
Ilio-colostomy	125.00
Appendectomy	100.00
Appendectomy and hemorrhoidectomy	125.00
Appendectomy and ventral herniorrhaphy	150.00
Appendectomy and inguinal herniorrhaphy	137.50
Herniorrhaphy ventral	
with intra pelvic procedure	125.00
with hysterectomy	150.00
Cholecystectomy	125.00
Choledochotomy	150.00
Colostomy, distinct procedure	100.00
Colostomy, preliminary	75.00
Colostomy, closure of	75.00

Proctology

Hemorrhoidectomy	$ 50.00
Anal fistulectomy	50.00
Anal fistulectomy, multiple tracts	75.00
Proctoscopy	15.00
Fissurectomy	25.00
Fissurectomy with hemorrhoidectomy	65.00
D and C ext. hemorrhoidectomy	42.50
Abscess, ischio-rectal, inc. and dr.	50.00

Urology

Cystoscopy, diagnostic	$ 25.00
Cystoscopy, retrograde	35.00
Cystoscopy, with fulgration	50.00
Cystotomy	75.00
Cystotomy, with removal of calculus	100.00
Prostatectomy, suprapubic	150.00
Prostatectomy, perineal	100.00
Transurethral resection	100.00
Nephrectomy	150.00
Hydrocele, radical op.	50.00

*Obstetrics**

Full term, spontaneous delivery	$ 50.00
Breech extraction	65.00
Low-forceps	65.00
Mid-forceps	75.00
Version	75.00
Caesarean	100.00

Gynecology

Dilatation and curettage	$ 25.00
post abortive	35.00
Perineorrhaphy	50.00
Amp. of cervix	50.00
Cervico vaginal repair	
more than two procedures	100.00
Amp. of cervix and perineorrhaphy	75.00
Uterine suspension	100.00
Manchester or interposition	125.00
Prolapse, abd. and vag. procedure	125.00
Hysterectomy, supra cervical	125.00
Hysterectomy, with cervix	150.00
D and C with laparotomy	112.50
with hysterectomy	150.00

Thoracic Surgery

Bronchoscopy, initial	$ 75.00
Bronchoscopy, subsequent	25.00
Empyema, rib resection	75.00
Thoracoplasty, first stage	100.00
Thoracoplasty subsequent	50.00
Phrenic nerve, crushing or evulsion	50.00

*(Do not include pre-natal or post-natal services rendered prior to admission or following discharge from hospital.)

Neuro Surgery

Ventriculogram or encephalogram	$ 50.00
Decompression, Subtemporal	100.00
Craniotomy, tumor, abscess, nerve	150.00
Laminectomy	150.00
Thoracolumbar sympathectomy	150.00
Pulmonary plexus nerve block	25.00

Nose, Throat, Ear

Tonsillectomy and adenoidectomy	$ 40.00
Submucous resection	50.00
Caldwell-Luc	75.00
Canfield	65.00
Frontal or ethmoid radical	100.00
Paracentesis tympani	10.00
Mastoidectomy simple	100.00
Mastoidectomy, radical	125.00
Submucous and tonsillectomy	70.00
Submucous and polypectomy	60.00

Ophthalmology

Chalazion, excision	$ 10.00
Lachrymal sac, excision	50.00
Pterygium, excision	50.00
Strabismus, complicated	100.00
Iridectomy	50.00
Cataract, removal	100.00
Enucleation	50.00
Enucleation with cartilage implant	100.00

Orthopedics

Tendon repair	$ 35.00
Each additional: $15.00, not to exceed	100.00
Hallux rigidus	50.00
Hallux valgus	75.00
Arthrotomy, except semi-lunar	75.00
Osteomyelitis, long bones radical	75.00
Sequestrectomy long bones	50.00
Bone graft, long bones	150.00
Spinal fusion	150.00
Arthrodesis, multiple, flatfoot	100.00

Fractures Simple†

Skull, payable on medical basis	
Nose	$ 25.00
Radius or ulna	25.00
Radius, upper third	35.00
Both bones, forearm	35.00
Clavicle	25.00
Humerus	50.00
Tibia	50.00
Tibia and fibula or potts	75.00
Fibula	25.00
Femur	75.00

†(For fractures treated by open reduction, traction and extension, Kirschner Wire or Pins, add per cent but in no case will benefit payable by Plan exceed $150.00.)

ORTHOPEDIC SOCIETY ORGANIZED

The New Jersey Orthopedic Society was organized on October 12, 1946, at a meeting held at the Monmouth Memorial Hospital in Long Branch. Nineteen orthopedic surgeons attended the meeting and became founders of the Society. The following were elected to office:

President — Leopold Szerlip, Newark
Vice-President — Harold W. Smith, Orange
Secretary-Treasurer — Raphael R. Goldenberg, Paterson

In addition to the above named, the following were present at the initial meeting: Toufick Nicola, Nicholas Ransohoff, Bernard Halbstein, Harold T. Hansen, John J. Flanagan, Henry H. Kessler, H. Wichman, F. I. Schwartzberg, R. R. Ciccone and William Kruger.

All members of the Society are diplomates of the American Board of Orthopedic Surgery.

At the first meeting the following program was presented:

1. Curare, Intocostrin, and Intensive Physical Therapy in acute anterior poliomyelitis (Movie Film)—Dr. Nicholas Ransohoff.
2. Bunnell Operation for Opponens Paralysis—Dr. Nicholas Ransohoff.
3. Surgical Approach to Chronic Low Back Pain With and Without Sciatica—Dr. Nicholas Ransohoff.
4. Osgood—Schlatter's Disease — Surgical Excision —Dr. Bernard Halbstein.
5. Axial Wire Fixation of Metacarpal Fracture—Dr. Bernard Halbstein.
6. Anterior Capsulectomy for Flexion Contracture of Elbow Joint Following Trauma—Dr. Philip Willner.
7. Plastic Repair of Congenital Amniotic Bands—Dr. Nicholas Ransohoff.

NEUROPSYCHIATRISTS WANTED

The Veterans Administration announces numerous openings for neuropsychiatrists in New Jersey and Eastern Pennsylvania. Salaries range up to $10,000 per annum, depending upon the applicant's qualifications. Further details are obtained from the Chief, Neuropsychiatric Section, Veterans Administration, 128 North Broad street, Philadelphia 2.

OBITUARIES

DR. SAMUEL BARBASH

An exceptionally active and productive professional life came to an end on November 14, 1946, with the death on that day of Dr. Samuel Barbash, medical director of the Atlantic City Hospital. Born in Austria in 1884 he was brought to Philadelphia when only four weeks old and attended the public schools of that city. He was graduated from Medico-Chirurgical College in 1905 and after interning at the Atlantic City Hospital, settled in that community. Since 1939 he had been a member of the State Board of Medical Examiners and held the distinction of being the first ever to hold the president's chair in that board for two terms. In 1935 he became medical director of the Atlantic City Hospital and was instrumental in the construction of the new Pine Rest institution. He was a diplomate of the American Board of Internal Medicine and a Fellow of the American College of physicians. For a long time he was Editor of the Bulletin of the Atlantic County Medical Society. He was for many years an active participant in the counsels of The Medical Society of New Jersey.

DR. CHRISTOPHER C. BELING

New Jersey lost its senior neuropsychiatrist with the death on November 30, 1946, of Dr. Christopher C. Beling. Dr. Beling was born in Ceylon, India, in 1873, and was graduated from the Royal College of Surgeons at Edinburgh in 1900. He then came to the United States and worked on the staff of the New Jersey State Hospital at Morris Plains until 1907. In that year he went to Newark and was one of the first physicians in the history of this state to go into the private practice of neurology and psychiatry. He established professional contacts with most of the hospitals in northern New Jersey and at the time of his death was chief of the neuropsychiatric service of the Newark City Hospital.

He was president of the Morris County Medical Society in 1907 and president of the Physicians' Club of Newark In 1918. Since 1923 he has been a member of the Judicial Council of The Medical Society of New Jersey and for many years was chairman of the Committee on Medical Defense and Insurance of the Society. He was one of the founders of the New Jersey Neuro-Psychiatric Association and was the first president of that organization when it was formed in 1932. Dr. Beling fathered the first neuropsychiatric clinic in New Jersey, which he set up in St. Michael's Hospital in Newark in 1908.

DR. CLYDE M. FISH

One of South Jersey's senior practitioners passed on, on November 21, 1946, when Dr. Clyde M. Fish died at the Atlantic City Hospital. Dr. Fish was well known in Atlantic County as a specialist in the field of internal medicine, particularly in tuberculosis. Born in Bath, Pa., in 1875, he was graduated in 1897 from the Jefferson Medical College and first came to New Jersey to serve an internship in the Atlantic City Hospital. He was for many years medical director of the Atlantic County Hospital for Tuberculosis and carried on his private practice in Pleasantville from 1899 until his death last year. He was a past president of the Atlantic County Medical Society and an active member of the American College of Physicians.

DR. JOSEPH A. KOPPEL

Dr. Joseph A. Koppel of Jersey City died on November 1, 1946. Born in central Europe in 1878, he came to the United States in early childhood and attended Ohio Wesleyan University, from which he was graduated in 1904. After practicing in Cleveland for a year, he moved to New Jersey and since 1905 had been engaged in active general practice in Jersey City.

OPHTHALMOLOGIC PRIZE CONTEST

The National Society for the Prevention of Blindness offers a prize of $500 for an original paper on glaucoma. Closing date for the receipt of papers is December 1, 1947. Further details are obtained by writing to the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

PROBLEMS IN PRESCRIPTION WRITING

Two lectures given by Dr. Thomas Rowe, Dean of the Rutgers University College of Pharmacy, on "Prescription Writing" will be heard on the nights of January 14 and 28, at 8:00 p. m., at the College Building, 1 Lincoln avenue, Newark 4, N. J. Each lecture is complete in itself and well worth attending. Dr. Rowe presents various prescription writing problems at these sessions, all of which are of interest to practicing physicians. The course was originally intended for interns, but has proved of equal interest to men of long experience.

VETERANS CARE PLAN

E. T. Yorke, M.D.

The profession has played a magnificent part in the success of the veterans treatment program. Only by its magnanimous cooperation has the medical care granted by Congress been administered to the veteran having service-connected disability.

The greater availability of medical treatment for veterans in New Jersey than elsewhere stems from the cooperation of the profession plus the fact that V. A. in New Jersey went ahead with the program as early as March, whereas many areas still do not show many veterans under medical care. New York did not get its program going until August.

Two factors making medical care available to veterans here were: (1) physicians treating veterans without waiting for authorization from V. A. and (2) establishing service connection without requiring a Rating Board examination, a liberal concession to the veteran made possible through direct effort of the N. J. medical profession.

The coming of General Omar Bradley as Administrator and Dr. Paul Hawley as Chief Medical Director of V. A. brought the principal of free choice of physician, something new in V. A. history. Instituting such a program required a progressive spirit strong enough to overcome edicts in moth-eaten regulations.

As for the profession, I have met some who just treat veterans without notifying V. A., thereby escaping the discomfort of being buried under paper. Others have politely informed V. A. that they have no time for such work. Certain doctors treat with abundance, thinking the veteran is entitled to every consideration. Their bills become a little fat. V. A. declares this a defect and is concerned about it. All requests for overabundant treatment come under careful scrutiny. This has been frequently discussed in V. A. medical staff meetings. More than once I have been asked to concoct a remedy against "overtreatment." I have emphasized, and V. A. has agreed, that such a "defect" is rare.

Dr. Jacques, Philadelphia Branch Office, has informed me of the existence of a V. A. Bureau of Investigation, although cases in which physicians show inaptitude in bookkeeping are referred to me. Veterans are sometimes ordered to report to the Newark office for questioning by V. A. beforehand.

STATUS OF CIVILIAN PHYSICIANS

Dr. R. C. Fagley, Chief Medical Officer, Newark, studies all V. A. circulars affecting the medical division. Number 252, issued in October, stresses the use of V. A. field stations to the maximum in treatment and in examining for pensions. Only when these field stations cannot handle the load, should V. A. use civilian physicians. He has put small staffs in contact offices in Camden, Paterson and Jersey City. Other offices will be opened in Trenton, Union City, Morristown, Perth Amboy, Elizabeth, Bridgeton, Red Bank, Dover, New Brunswick, Burlington, Hackensack, Newton and Atlantic City.

V. A.'s need for civilian physicians will diminish in proportion to the development of its contact offices. Yet, no treatment has been administered in Paterson and Camden.

The program as we have it was stimulated by Dr. Hawley because of his conviction that the veteran's interests are best served by allowing him free choice of his physician.

V. A. ESSENTIALLY ADMINISTRATIVE

In the treatment program, V. A.'s role is essentially one of administration. I have deplored the fact that V. A. was too far in arrears administratively to be taking on clinical work on an increasing scale. It was my opinion that V. A. should first accomplish its administrative duties since they were the primary functions. Pronounced lag in issuance of authorizations for treatment and paying bills seemed to justify my stand.

V. A. can eliminate the administrative job only when it will do all treatment and all pension examinations. At the present, V. A. cannot take Circular 252 seriously, because it cannot do even a fraction of the treatment program. And 25,000 pension cases are available for the examining units. By doing these for V. A., we will remove a sizable administrative burden. When Dr. Jacques intimated that we weren't saving much for V. A., I invited an unbiased cost analysis. I pointed out the involved V. A. operations circumvented by (1) issuance of blanket authorization listing several examinations on the one piece of paper

and (2) the submission of a machine records bill. One can visualize the handling of thousands of individual bills and the trouble as compared with checking a precision, machine-made bill.

ECONOMIES RECOMMENDED

The medical profession may be direct beneficiaries of a large tax-spending project, but we favor every possible cut in costs. I am on record describing the methods which would not only cut V. A. administrative costs to a third but do away with the annoying lag.

Seventy-six per cent of the veterans reside in eight counties: Essex, Hudson, Bergen, Union, Passaic, Middlesex Camden and Mercer. They cover a compact area. Contact offices already exist in four of them, serving 49 per cent of the veterans.

I recommended the use of a single form showing (1) the authorization to the physician, (2) treatment and clinical record and (3) the physician's bill. The savings to V. A. in the billing alone would be tremendous because of the uniformity. (See below, *What's In a Name?*) Current objections to the use of such a form seem to lie in regulations, which, I believe, can be circumvented.

In this large program are four factors: (1) a service-connection ruling by V. A., (2) issue of authorization by V. A., (3) treatment of the veteran by a physician and (4) paying the bill. The factor causing the least inconvenience to V. A. and the crux of the entire program is the treatment of the veteran by a physician, who in most instances has persisted in going ahead in spite of factors (1), (2) and (4). The profession was admonished in this Journal to have patience with the finance officer (factor No. 4), but should have been congratulated for making the veterans treatment program a success notwithstanding the fact that V. A. was also in arrears in factors (1) and (2). No one will find a better example of magnanimity than that shown by the medical profession in administering care to the veteran. No other group of people would begin to render service to veterans without first having certain guarantees on paper.

Formal complaints by physicians coming to my office on any score have been rare. But they have voiced their opinions freely in conversations on my frequent trips to the counties during the last four months.

Had Medical Service Administration been able to continue as a clearing house between V. A. and the physicians, there would have been a progressive simplification of administration.

Requiring authorization from V. A. before the initial treatment should be added to the use of an improved single form (authorization, clinical record and bill). V. A. could begin with the four offices already in operation and serving 49 per cent of the veterans. As V. A. contact offices come into existence the improved V. A. administration could then be expanded accordingly.

There are undesirable features to cooperating with V. A. without first having an authorization to treat veterans. Overtreatment lies with the veteran more than with the physician and can be cut to a minimum if V. A. would issue immediate authorizations. This may seem to put V. A. in a dictatorial position, because they would prescribe the number of treatments also. Yet, V. A. would not deprive a veteran of additional treatment should conditions warrant and the attending physician describe them adequately. Bona fide emergencies could be handled by telephone, and if they were up to date, V. A. would have the authorization in the physician's hands within seventy-two hours.

The moral interests of the profession are not protected under the present system of delayed authorizations.

ILLEGIBLE HANDWRITING

That the hand-writing of certain physicians is atrocious cannot be denied; V. A. makes the appeal that these physicians please write their reports so personnel may descipher them without great expenditure of time.

WHAT'S IN A NAME?

You have only one name that is recognized by the finance office of V. A. My name, for instance, is Edward T. Yorke. If I bill V. A. in the name of E. T. Yorke or Edward Thomas Yorke, a clerk must certify in writing that these are names of the one and same individual before finance will acknowledge the bill.

Physicians who use any of the variations of their names instead of copying The Name as it appears on the authorization cause endless pages of such certifications and seriously impede the administrative functions involving payment of bills.

This also applies to the name of the veteran; so I have been asked to have you *copy the veteran's name just as it appears on the authorization,* to save endless pages of certifications.

COUNTY ROLL CALL

Having been operating several months unofficially, the *Monmouth* Plan began scheduling examinations under its new contract with V. A.

in November. The participating physicians of the *Hudson* Plan met at Jersey City, November 26, to hear a member of the V. A. Rating Board discuss the features of a report fit for rating purposes. This Plan will hold examining sessions at the Jersey City Medical Center every Tuesday. Another unit will open in St. Marys Hospital. *Mercer* Plan will have four units. The *Middlesex County* Medical Society adopted the Plan unanimously and arranged for its first unit at Roosevelt Hospital in Metuchen. *Essex* Plan has arranged for a unit at Newark's Lutheran Hospital. *Union* adopted the Plan January 8. The *Warren-Hunterdon* Plan will function at Phillipsburg. *Passaic* will have more than one unit. The *Morris* Plan will function in Morristown, *Atlantic* Plan in Atlantic City, and *Burlington* Plan in Riverside. *Somerset* has a Veterans Liaison Committee.

MONMOUTH LEADS THE WAY

Before the Veterans Administration could organize to meet the needs of veterans being discharged from service and before the end of 1945, certain physicians in Monmouth County, led by Dr. William G. Herrman and Dr. Granville Jones, president of the Monmouth County Medical Society, offered to form a sorting clinic composed of specialists to pass upon the medical needs of returning veterans. Their offer was accepted by General Hawley and they operated from October 10, 1945, to March 1, 1946, giving their services gratis. The two local hospitals in the county gave free service and free nursing care and the Monmouth County Organization for Social Service gave their assistance without cost to the veteran, or the government.

The clinic would examine veterans as a service offered by the medical profession. Their disabilities would be considered from the medical point of view. Veterans needing hospitalization would be assisted by actual arrangement for hospitalization in an army or civilian hospital. Other problems were evaluated for the veteran and his relations with physicians preserved. The V. A. provided their representatives at each clinic to assist in the work.

In Monmouth County the physicians are closely allied with the Organization for Social Services. Their combined work is carried out intelligently and, in medical problems well guided by the viewpoint of physicians.

After the Veterans Administration entered into agreements with The Medical Society early in 1946, the need for the clinics in Monmouth County became altered. Yet, meeting difficulties in getting men examined, V. A. made arrangements with the Monmouth physicians to examine in clinics those needing one or more types of special examinations.

Seeing that formal agreements were necessary, V. A. approached the Monmouth physicians for such an agreement. Whereupon the Monmouth physicians organized formally into a nonprofit corporation, called the *Monmouth Plan for Veterans Medical Care*. The Monmouth Plan was not a product of the Veterans Administration, nor was is established principally for the convenience of the Veterans Administration. The Plan is dedicated to the care of veterans. Most of its trustees are physicians, assisted by lay people representing minds having certain public interests.

The Monmouth Plan is an approach by physicians to coordinate a variety of interests dealing with certain aspects of public health. The physicians in Monmouth County are not standing by to let someone else do things.

Responsibilities of the trustees of the Plan are purely moral. The Plan has no obligation until it enters into one, deciding on its own what obligations it should make. It is taken for granted that the trustees will study any proposal which is considered judicious to support.

The Plan in Monmouth was the first to undertake an agreement with V. A. in this country to establish "clinics" and endorse specialists for the examination of veterans for pension purposes. The Plan is guided by physicians and is responsible to the medical profession. It is a step forward in supplying medical service under the sponsorship of the County Medical Society.

There is more to the idea than the simple project of examining veterans for pension. As they are being established in the counties, the Plans, copied after the one in Monmouth, are opening a way for V. A. to carry a load which it could not handle under any other circumstances. More veterans will be examined. More physicians will be called upon to make examinations. Their product will be better coordinated. The reports will have that quality (which is lacking almost everywhere in the country) of fitness for rating purposes.

The Plans signify action. There was a need. The medical profession in the counties has met that need and has maintained the integrity of its own physicians in dealing with government!

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

RAPID TREATMENT FOR SYPHILIS

Under the plan administered by the Division of Venereal Disease Control of the State Department of Health, free hospitalization and penicillin are available for patients with syphilis if less than one year's duration. Most general hospitals in New Jersey will accept patients under the plan when beds are available. If arrangements cannot be made for a bed in a local hospital, get in touch with the public health nurse in your area or phone directly to the Division of Venereal Disease Control (Trenton 2-2131, Extension 705)). Immediate arrangements will be made for admission of the patient at some hospital in the state.

The Division suggests that the penicillin treatment scheduled for syphilis include also a small amount of an arsenicals and bismuth. Recommended dosage of penicillin has not been changed (40,000 units of sodium penicillin every two hours for sixty doses, a total of 2,400,000 units). The additional treatment suggested is as follows:

1st day—One-half the appropriate dose (accord- to body weight) of phenarsine hydrochloride or marpharsen.
3rd day—Full dose.
5th day—Full dose.
On 1st, 3rd and 5th days—0.2 Grams of bismuth (2 cubic centimeters of bismuth subsalicylate) given intramuscularly.

Some physicians give an initial dose of an arsenical as soon as the diagnosis of early syphilis is established. This is considered good practice to reduce the danger to others while arranging for admission to the hospital for rapid treatment.

IMPROVED PUBLIC HEALTH LABORATORY SERVICES

With the return of trained laboratory personnel from the services the Bureau of Bacteriology of the State Department of Health has initiated a number of improved technics and procedures to give the physicians submitting specimens better information on the tests. The additional services include routine virulence tests and sugar reactions on all throat specimens where organisms resembling C. diphtheria are present. The culture is not reported as positive for C. diphtheria until checked biochemically and proved by positive virulence test. Blood agglutination tests for enteric diseases are now reported for O and H antigens and a routine check for undulant fever is performed. Feces and urine specimens are routinely checked for organisms of the Eberthella, Salmonella and Shigella groups. Where an organism is identified as a Salmonella, it is classified by group as A, B, C, D, E, or F. The Bureau now has an agreement for identification as to specific species with the Salmonella Typing Center. The State Laboratory can, therefore, offer local and hospital laboratories better aid in the identification of culture isolated in their laboratories.

SEROLOGIC TECHNICS IMPROVED

The technic and supervision of the large number (275,000) of serologic specimens for syphilis has also been improved and the Bureau of Bacteriology obtained the best rating it has ever made in the Mazzini,, Kolmer and Kahn tests last year in the annual evaluation study conducted by the U. S. Public Health Service.

More than a year ago, the State Laboratory adopted the routine procedure of using the Mazzini slide test as the screening examination for all blood specimens. All serums giving any degree of re-activity "doubtful" or "positive" with the flocculation test are confirmed by Kolmer or Kahn tests. It is gratifying to note that the Medical Advisory Board of the New York City Department of Health has recently recommended that the New York City Health Department Laboratory add this procedure as standard.

LABORATORY STUDIES IN TROPICAL DISEASE

Every practitioner should know that in addition to the routine and regular diagnostic services available there, the following special laboratory services will be performed by the N. J. State Department of Health (Bureau of Bacteriology). The last column indicates the specimen which the physician should send.

For a reprint of the following table, write to Department of Health, Trenton 7, N. J., and ask for the list of *Laboratory Examinations for the Diagnosis of Tropical Disease.*

DISEASES	LABORATORY EXAMINATION	SPECIMEN TO BE SENT
Bacterial infections: Typhoid Paratyphoid Dysentery	Cultural examination of feces and urine	Stool specimens submitted in our regular containers. Do not throw away the glycerine solution in container as it acts as a preservative
Undulant fever Tularemia	Macroscopic examination of blood with B. abortus or tularense antigen	Send blood in our Wassermann containers. Mark plainly type of examination desired
Rickettsiae infections: Rocky Mtn. Spotted fever Typhus fever Tsutsugamushi	Macroscopic examination of blood with Proteus culture OX19, OX2, OXK.	Send blood in our Wassermann container. Mark plainly type of examination desired
Blood Protozoa: Malaria parasite: P. vivax P. falciparum P. malariae	Microscopic examination of blood and identification of plasmodia	Blood smears submitted in our containers. Series of thin and thick blood smears. Thick smear: the size of a dime and just able to read print through it.
African trypanosmes Trypanosoma cruzi American	Microscopic of blood Microscopic of blood	Use our malarial outfit. State type of examination desired. Series of thin and thick blood smears.
Blood helminths: Filaria Wuchereria bancrofti Wuchereria balayi	Microscopic of blood for microfilariae	Use our malaria outfit. Thick blood smear as for malaria. Fresh blood smears
Schistosoma hemotobium	Microscopic for ova	Use our typhoid outfit, discard glycerine solution, wash thoroughly. Series of specimens of urine. Mark type of examination
Schistosoma mansoni Schistosoma japanicum	Microscopic for ova Microscopic for ova	Use our typhoid outfit, discard glycerine, wash thoroughly. Series of specimens of feces.
Clonorchis sinesis	Microscopic for ova	Use our typhoid outfit, discard glycerine solution, wash thoroughly. Series of specimens of feces
Tissue helminths: Trichinella spiralis	Microscopic of teased muscle tissue, digestion of muscle or suspected food	Sample of pork or suspected food.
Intestinal Protozoa: Endameba histolytica Giardia lamblia Balantidium coli	Microscopic for Cysts Microscopic for vegetable or trophozoite form	Use our typhoid outfit, discard glycerine solution, wash thoroughly. Series of normal stools. Do not give patient oil, iron or bismuth before taking stool. Send patient to laboratory for examination of fresh stool for trophozoites.
Intestinal heiminths Ascaris lumbricoides Diphyllobothrium latum Fascialopsis buski Hookworms Hymenolepsis nana Strongyloides stercoralis Taenia (tapeworms) Trichuris trichiura	Microscopic for ova Direct and microscopic for adult forms or segments	Use our typhoid outfit, discard glycerine solution, wash thoroughly. Series of normal stools. Aduit worms or segments.
Enterobius vermicularis	Microscopic for ova. Direct for adult worms	Series of swabs from perianal region.

COUNTY SOCIETY REPORTS

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society,* held at Bergen Pines Hospital, Oradell, on November 12, 1946, was called to order by the President, DR. ALBERT W. CLOUD, at 9:10 p. m.

Minutes of the regular meeting of October 8, were accepted as read by the secretary. Minutes of the Executive Committee meeting of October 15, 1946, were approved as published in the BULLETIN.

On recommendation of the membership committee, the following were elected to full membership: Dr. Andrew C. Ruoff, III, Riverdale (by transfer from Hudson County); Dr. George W. Caldwell, Tenafly (by transfer from New York County) and Dr. Dino D. Calabrese, Fort Lee. Dr. S. Harvey Sklar, Cliffside Park and Dr. Anthony M. Susinno, Palisades Park, were elected to associate membership.

Dr. Knowles moved that the Budget for the year 1947, as it appeared in the BULLETIN, be accepted. Motion was seconded and carried.

The speaker of the evening, DR. GEORGE M. LEWIS, Associate Professor of Medicine (Dermatology), Cornell University College of Medicine, was introduced by DR. GEORGE HELLER. He gave a splendid bird's-eye view of all the *Newer methods of therapy in dermatology.* The talk was illustrated profusely with excellent lantern slide reproductions, illustrating the conditions discussed.

CAMDEN COUNTY

J. C. Lovett, M.D., Reporter

The Centennial Anniversary was celebrated by the *Camden County Medical Society* with a dinner in the ballroom of the Walt Whitman Hotel on November 7, 1946. DR. THOMAS B. LEE, chairman of the arrangement committee, introduced DR. HENRY B. DECKER, the society's president, who served as toastmaster.

Dr. Decker introduced the officers of the society and also the distinguished guests who were DR. PAUL, Secetary of the Philadelphia Medical Society; DEAN ALBERT E. MEDER of Rutgers University; DR. ROBIN C. BUERKI, Dean of the University of Pennsylvania Graduate School of Medicine and DR. RALPH HOLLINSHED of the Gloucester County Medical Society.

Dr. Decker gave an interesting talk on the *History of the Camden County Medical Society.* The prime mover in organizing the Society was DR. RICHARD M. COOPER who also provided in his will for the founding of the Cooper Hospital in Camden.

Dr. Hollinshead brought the greetings of the Gloucester County Medical Society.

Dean Meder gave an interesting and practical talk on *Liberty and Prosperity.*

Dr. Buerki spoke on *The Future of Medicine.* He warned against confusing group medicine with socialized medicine. He felt that the hospital should be the center of the community along with the school and church.

CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

Thirty-five members attended the regular monthly meeting of the *Cumberland County Medical Society* at Richard's Farms Rainbow Lake, Vineland. DR. ALBERT KUMP, its president called the meeting to order at 2:30 p. m., December 10, 1946

Guests were Dr. Lee Humbel, Dr. Louis Collins, Dr. Harold Henderson and Dr. Ralph Phillips.

DR. CHARLES CUNNINGHAM reported on the formation of a plan for examining veterans, to be known as the "Cumberland Plan for Veteran's Medical Care". He introduced DR. EDWARD T. YORKE, state liaison officer to Veterans Administration, who briefly explained the program.

Our county has just organized a chapter in the New Jersey division of the American Cancer Society. Dr. James Knowles, Dr. Anthony Pino and Dr. George Thomas were appointed to the executive committee for the chapter, representing our medical society.

Resolutions were read to the members of the society memorializing DR. HELEN WEITHAASE and DR. J. FRANKLIN REEVES, both of whom passed away recently.

DR. MICHAEL SCOTT, Head of the department of Neuro-surgery at Temple University Medical School, Philadelphia, Pa., presented an interesting discussion on *Diagnosis and Treatment of Low Back Pain and Sciatica.* He stressed the more difficult cases rather than the simple ones and reviewed the symptoms of those cases especially due to disc herniation. His talk was illustrated with lantern slides.

A dinner was served following the open discussion of this subject.

GLOUCESTER COUNTY

D. R. Brewer Jr., M.D., Reporter

On Thursday evening, October 17, 1946, the Woman's Auxiliary was entertained by the *Gloucester County Medical Society* at the annual social session held at Silver Lake Inn, Laurel Springs.

Speaker of the evening was J. LYNN MAHAFFEY, M.D., Director of the State Department of Health. Dr. Mahaffey described the subdivisions and duties of the Department of Health and of the great aid that is rendered to the physicians of New Jersey. He also encouraged the men to be receptive to any appointments on the State Board of Health.

A silver dish was presented by the society to Mrs. Frederick Wandall of Clayton, in honor of her election to the state presidency of the Woman's Auxiliary.

This social session marked the first absence in many years of Henry B. Diverty, M.D., who was ill. Dr. Diverty has been practicing medicine in Wodbury for over 55 years. He is the Senior member of The Medical Society of New Jersey, and in honor of his long and conscientious attendance at meetings of our society, he was made a life member of the Gloucester County Medical Society.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

On November 6, 1946, *Hudson County Medical Society* held its regular monthly meeting at the Masonic Club in Jersey City. The president, DR. C. E. MCNENNEY, presided.

The following resolution on the passing of DR. REEVE L. BALLINGER was read by DR. WILLIAM J. GLEESON. It was prepared by Drs. Gleeson, Evans and Jaffin:

Whereas, God in His infinite wisdom has taken away our much loved and respected colleague and friend, Dr. Reeve L. Ballinger, and

Whereas, Dr. Ballinger has performed his professional duties with great care and steadfastness, and

Whereas, he has with utmost sincerity and competence met his responsibilities in the many positions he has held in the County and State Medical Societies, and

Whereas, his untimely passing from our circle leaves a grievous vacancy to us and to his dear family; *therefore,* be it

Resolved, That the officers and the Board of Trustees, acting for the entire membership of the Hudson County Medical Society, express to the bereaved family, our heartfelt sympathy for our mutual and irreparable loss through the death of Dr. Reeve L. Ballinger.

Applicants elected to membership were: Dr. Milton G. Abarbanel, of Bayonne; Dr. Isidore Edelstein of Hoboken; Dr. Arthur R. Borchek, of North Bergen; Dr. Leonard Lieberson of West New York; and Dr. Charles K. Brauer, Dr. George J. Costa, Dr. Robert Horowitz, Dr. Mary Gloria Jaksch, and Dr. Max N. Pusin, all of Jersey City. It was announced that Dr. Lewis Schwartz of Jersey City had been passed by the Board of Censors for reinstatement.

Dr. McNenney introduced the guest speaker DR. JAMES S. GREENE, Medical Director, National Hospital for Speech Disorders, New York City. The subject of Dr. Greene's address was *Speech and Voice Disorders: Etiology and Therapeutic Procedures.* Dr. Greene illustrated many phases of his work by means of lantern slides and recordings made by patients before and after treatment, and presented a patient who, subsequent to laryngectomy, has succeeded in developing a faculty of speech that is proving satisfactory in his business and social relations. One remarkable illustration was the recorded speech of a seventy-six year old man whose entire tongue had been removed surgically because of carcinoma.

Discussants of Dr. Greene's paper were Drs. Figurelli, Schorr, Tidwell and Londrigan; also Miss Sarah Walsh, Supervisor of Speech Correction in Jersey City public schools, who, together with several instructors in speech correction, attended this meeting by invitation.

MIDDLESEX COUNTY

M. M. Dunham, M.D., Secretary

Regular monthly meeting of the *Middlesex County Medical Society* was held on Wednesday, November 20th, 1946, at the Roosevelt Hospital in Metuchen, with the members of the Middlesex County Pharmaceutical Association as guests.

DR. C. HOWARD ROTHFUSS, the president, called the session to order at 9:15 p. m., and welcomed the pharmacists to the meeting.

On recommendation of the ethics committee, the following associate members were elected to full membership: Doctors Lydia Adler and Walter Grossman of New Brunswick; Dr. Benjamin Cannata of Perth Amboy, and Dr. Eric Putter of Milltown.

On further recommendation of the ethics committee, the following applicants were elected to associate membership: Dr. James S. Winn, Bound Brook; Dr. Alexander K. Niemiera and Dr. Louis F. Gould of Perth Amboy; and Dr. Irving Zuckerberg, Perth Amboy, on transfer from the New York County Medical Society.

Committee reports were presented.

MR. STEPHEN DUSCHOCK, president of the Pharmaceutical Association introduced the speaker of the evening, MR. DANIEL A. BELMONT, New York District Narcotics Division, who spoke on *Narcotics Prescription Writing.*

The meeting was adjourned at 12:30 a. m.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

DR. NORMAN L. HIGINBOTHAN was the speaker at the regular monthly meeting of the *Monmouth County Medical Society* held at the Monmouth Memorial Hospital in Long Branch on November 27, 1946. DR. JAMES PRAGNALL presided. Dr. Higinbothan presented an enlightening and interesting paper on *Newer Concepts in Diagnosis and Treatment of Malignant Bone Tumors.* Dr. Higinbothan emphasized the importance of a careful history. Any record of trauma may be especially important medico-legally as there is a precedent history of trauma in about fifty per cent of these cases. The symptoms and physical signs were listed and discussed. Pain is usually the first symptom followed by local swelling. Loss of weight is a late manifestation. Dilation of the superficial veins around the tumor is often seen. Treatment is surgery or irradiation. Slides were shown of some of the tumors. The infrequency of the malignancies were noted.

Discussion was opened by Dr. Ransohoff. Dr. Herrman and Dr. Fergensen also presented their opinions.

The scientific session was immediately followed by the business meeting. Permission to employ an Executive Secretary was requested, and unanimously granted. A report of the Executive Committee was given.

Dr. Anthony Rifici was elected to full membership. Dr. Francis Ginto, Dr. Paul Isen, Dr. Harold McGreevey and Dr. Frederick Steller were elected to associate membership.

The Monmouth County organization of First Aid Squads are receiving a refresher course in first aid under the auspices of the county medical society. This course consists of a series of ten lectures, two each week. These lectures are well attended and received. They will be completed during December.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday evening, December 10, 1946, at the Administration Building in Paterson, with Dr. Harry Wolfson, the president presiding.

After a short business meeting, at which Dr. Edward T. Lawless of Bloomfield was accepted for active membership (by transfer from the Essex County Medical Society) Dr. Wolfson introduced the guest speaker, Dr. John Dorsey Craig, Assistant Clinical Professor of Pediatrics at Post-Graduate Medical School, Columbia University. Dr. Craig spoke on *Communicable Diseases*, presenting an interesting informative discussion. In speaking of scarlet fever, he brought out the recognition of relationship between scarlet fever and streptococcus sore throat and discussed the treatment of scarlet fever with large doses of immune globulin. He cited the frequency of loss of hearing in mumps.

In view of the increasing incidence of diphtheria in the country, he stressed the importance of immunization, particularly against diphtheria, pertussis and tetanus.

UNION COUNTY

The following resolution was adopted November 6, 1946, by the *Union County Medical Society*:

On October 22, 1946, Otto Wagner, M.D., was called by a merciful Providence to join the large group of physicians who have previously passed to the Great Beyond. Dr. Wagner was born in Strasbourg and, after the completion of his academic studies, was graduated and licensed as a pharmacist.

In New York City, while connected with a prominent pharmaceutical house, he decided to study medicine. His degree was obtained from Cornell University and he then served as intern in the Elizabeth General Hospital.

For the past forty-three years he has practiced general medicine in this community and, by his genial manner combined with a thorough application of his ability to the study of disease, has endeared himself not only to a host of patients but also to all of his colleagues. In his death the medical profession of Union County has lost a great doctor who truly exemplified the ethical, conscientious and practical physician of the older school.

The Union County Medical Society desires to express to the family of Dr. Otto Wagner sincere sympathy in this, their hour of bereavement.

Charles H. Schlichter, M.D.
Horace R. Livingood, M.D.
Milton A. Shangle, M.D.

SOCIETY OF SURGEONS

Walter B. Mount, M.D., Secretary

On November 20, 1946, *The Society of Surgeons of New Jersey* held its Annual Meeting in Newark. Following officers were elected.—

President—Dr. Herbert W. Nafey, New Brunswick; First Vice-President—Dr. Royal A. Schaaf, Newark; Second Vice-President—Dr. Frank C. McCormack, Englewood; Secretary—Dr. Walter B. Mount, Montclair; Treasurer—Dr. Christopher A. Brokaw, Elizabeth.

The morning was devoted to the following operations at the Newark City Hospital:

Gastric Resection—Drs. Edward W. Sprague, Herbert A. Schulte and Royal A. Schaaf.

Gastric Resection—Dr. Harry N. Comando.

Closure of Cecostomy—Dr. Harry N. Comando.

Nephrectomy for Hypernephroma—Dr. Clarence R. O'Crowley.

Nephro-Lithotomy—Dr. W. Kenneth Wheeler.

Thoracoplasty—Dr. Richard H. Dieffenbach.

Also, there was a colored movie—Reconstructive Surgery of the Lower Extremity—by Dr. John J. Flanagan; and a Tour of the Pathological Laboratory and Museum—by Dr. Harrison S. Martland (by invitation).

In the afternoon the following papers were presented:

Pre-operative and Post-operative Handling of the Surgical Patient—by Dr. Joseph I. Echikson (by invitation); Recent Advances in Proctology—by Richard A. Hopping (by invitation); Treatment of Osteomyelitis with Saucerization and Early Skin Graft—by Dr. John J. Flanagan; Management of Recurring Bowel Carcinoma—by Dr. Charles M. Robbins; Neoplasms of the Testes—by Dr. Milton Friedman (by invitation); Clinical-Pathologic Conference—by Dr. Harrison S. Martland (by invitation).

HATS, HEALTH AND BALDNESS

Opinions of medical men in this country and abroad are in agreement that going hatless may be dangerous to the general health; may be harmful to the hair; and that wearing hats does *not* cause men to go bald.

A survey of 268 doctors in 41 cities across the country made by the Ross-Federal Research Corporation discloses that three doctors in five believe that going hatless may contribute to colds and heat prostration among men. Two doctors in three say baldness results not from hats but from other causes, mainly hereditary tendencies.

Baldness, the doctors said, is likely to arise from a number of causes that have nothing to do with hats. Of those surveyed, 51 per cent mentioned hereditary tendencies and 12 per cent blamed diseases. Other causes mentioned were glandular conditions, dandruff, nutritional deficiency, unclean scalp, mental strain, and organic disturbances.

—From the Hat Research Foundation,
358 Fifth Ave., New York City.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. F. G. Wandall, Clayton, N. J.

In many ways 1947 looks as if it will truly be a "Happy New Year", in the Woman's Auxiliary.

Membership was stressed and much has been accomplished. All the organized counties have had drives, and report many new members. Two dormant counties are active again. Unorganized counties are being continually approached, with the hope that a spark of interest will develop, and burst into flame.

Indoctrination, an objective carried over from one year to the next, has shown big strides this year. Several plans suggested by the Pubilc Relations department have taken root. Member-participation in county auxiliaries is being stressed. This gives more members an incentive to attend meetings and other functions. A closer bond between the county medical societies and their auxiliaries is being fostered. Following along the line of this latter plan,, several counties have instituted "Ladies Night", thus encouraging friendly relations between the doctors and their families. Some of the medical societies have invited— on occasion— the auxiliaries to scientific meetings; this procedure makes a better informed auxiliary. Then there are the public relations meetings which are being planned by the medical societies, throughout the state, with the auxiliaries assisting. This is as it should be.

Much is expected of physicians' wives, it is true. This is so, because we are partners in a most exacting and time consuming profession. Statistics show that physicians' wives are looked upon with favor in community organizations. Their opinions are respected, and their conduct and their decisions reflect their private lives as well as the profession. It is very important that Auxiliary members tell the people at large about the accomplishments in the field of medicine, using organizations as a medium of approach. This is truly public relations. Public relations is the open door between the medical profession and the lay people. There are many questions physicians' wives can answer in queries from the public. Over twenty-five million people know about and use the "Blue Cross" hospital plan. But do they know that in the coming year, hospital surveys will be carried on all over the United States, to insure the best in hospital facilities? Many thousands of lay people know about the "Medical Surgical Plan", a voluntary health insurance, that many states have set up; but do they know that seventy-five thousand physicians, (more than half of all privately practicing physicians) participate in this plan?

Such facts are policy building. They will augment the esteem with which the public looks upon the medical profession. We must get away from negativism and expound the constructive, far reaching program of our ever vigilant untiring Medical Society; and we can do this only by continuing to inform ourselves, through the Bulletin, the State Journal, the *Journal of the American Medical Association, Hygeia* and attendance at our county and state Auxiliary Meetings.

Let us keep before us a clear vision of the purpose for which our Auxiliary was formed, our unity of those purposes clearly defined, and we will accomplish our 1946-1947 goal, and be ready to sail on in our ship of state, to new objectives.

HYGEIA PROMOTION PROGRAM

Mrs. Edward A. Murphy, Chairman, Hygeia

Chief activity of the Woman's Auxiliary to The Medical Society, is, to promote the circulation of *Hygeia,* because it is the best medium for reaching the laity by informing them of the progress of medical science and of the scientific means for the prevention of disease.

The public needs authentic education by the American Medical Association, to counteract the quackery that so often confronts it. Since lay citizens are educated people in matters pertaining to health, and the science of medicine is being expounded to such a degree, then it behooves the medical profession to see to it, that the public is correctly informed. One source of correct information is *Hygeia.*

WHAT THE AUXILIARIES TO THE COUNTY MEDICAL SOCIETIES CAN DO TO HELP WITH THE CANCER WORK

By Mrs. A. Haines Lippincott, State Commander Woman's Field Army

No group of women should be more interested in the program for the control of cancer than doctors' wives. We are grateful to members of the Auxiliaries to the various county medical societies for the work they have done toward organizing the Field Army activities in New Jersey. Two of our county commanders, who are members, former state presidents—Mrs. Arthur J. Casselman, Camden, and Mrs. Richard J. McDonald, Passaic—have been outstanding in their achievements to build a firm foundation for the control of cancer in New Jersey.

The members of each county auxiliary can be of inestimable value by cooperating with the county commander in the fund raising campaign in April and by assisting with the educational program which includes interesting county and local organizations in having an educational program on cancer. Speakers and films will be provided. The Field Army is interested in increasing the educational facilities for informing the public, especially the poor and foreign groups in the state, through talks, motion pictures, literature, both English and foreign languages, exhibits, and directing persons to qualified doctors and clinics so that they may not fall into the hands of quacks. This is real public relations work.

Members can also be active in the lay service program which now consists chiefly of making surgical dressings, bandages, scuffs, bed gowns, comfort kits, etc., for cancer patients. As the counties become better organized our lay service program will be increased to include loan cupboards, information centers and nurses aides. Many volunteers will be needed to carry out this phase of the Field Army Program. If a member cannot give her personal service, she may donate her salvage material or donate articles that are needed by cancer patients.

The cancer control program in New Jersey also includes the following: Assisting in developing and supporting research program; creating new cancer clinics where necessary; assisting in establishing cancer diagnostic clinics; assisting in the maintenance of nursing homes for long-term patients; assisting in maintenance of a state-wide biopsy diagnostic laboratory and providing direct aid to the medically indigent cancer patient.

This entire program is under the guidance of the state and county medical societies and in cooperation with state and local health and welfare organizations.

Science wiped out yellow fever, solved small pox, controlled diphtheria, minimized typhoid, discovered sulfa, penicillin, streptomycin, radioactivity and atomic energy. Every day more information on what has been accomplished in the research field is being received. The atom has gone to work for medicine. Radioactive isotopes, by-products of A-bombs, have opened vast new fields. *Cancer can be conquered through education and research.*

AUXILIARY REPORTS

Atlantic County

Mrs. Samuel L. Salasin,
Chairman of Press and Publicity

A Yuletide Party was held at the home of Dr. and Mrs. James H. Mason, 3rd, at 5501 Atlantic avenue, Ventnor. Dr. and Mrs. James H. Mason, 3rd, were host and hostess to the members of the *Atlantic County Medical Society* and their wives on December 13, 1946.

The singing of the familiar Christmas carols was a pleasure and had the participation of all those present. Mrs. Rose Petings was the pianist for the community singing. A beautifully trimmed Christmas tree adorned the large rambling living room of the Mason domicile. Gifts brought by the members of the Woman's Auxiliary for the children of the Betty Bacharach Home were placed in high stacks under the tree. Christmas cheer prevailed throughout the evening. The first game used a hand-painted Christmas tree on a canvass placed on the sun parlor door. The object was to place the hand-painted canvass candle blindfolded in the center of the canvass tree. Mrs. Matthew Molitch was in charge of this, the winner, being Mrs. Daniel C. Reyner, who received a box of bubble bath. Mrs. G. Ruffin Stamps refereed the spelling bee. There were two teams the red and black, the black being the winning team. The three top spellers were, Mrs. Matthew Molitch, the winner, Miss Carline Kant, and runner up, Mrs. William O. Roop. The recipients received a bottle of toilet water and Dorothy Gray dusting powder.

The refreshment and decorating committee consisted of Mrs. Morton Major, Mrs. Matthew Molitch, Mrs. Samuel Halpern, Mrs. Harold Davidson, Mrs. Hilton S. Read, Mrs. Anthony Merendino, Mrs. Max Gross, Mrs. Daniel C. Reyner, Mrs. Louis Rosenberg, Mrs. Charles Hyman, Mrs. Harry Subin and Mrs. G. Ruffin Stamps.

An out-of-town guest at this party gave a generous cash donation of a hundred dollars for the benefit of the children at the Betty Bacharach Home. Distinguished guests present included: Dr. and Mrs. Lawrence A. Wilson, president, respectively, of the Atlantic County Medical Society and the Woman's Auxiliary, Dr. Louis H. Clerf, chief of laryngology and bronchoscopy at the Jefferson Hospital of Philadelphia, and Dr. George Willauer, Assistant Professor of Surgery at the Jefferson Medical College. Professor Willauer's talk on *Pulmonary Tumors* proved instructive and interesting to all physicians present.

The Auxiliary met again on January 10, 1947, at the Traymore Hotel. A moving picture on safety featured this meeting.

Burlington County

Mrs. John C. Voss, Chairman of Publicity

The *Auxiliary to the Burlington County Medical Society* held the first regular meeting of the fall on November 11, 1946, at the home of Mrs. Anthony Ziccardi of Maple Shade.

Due to the illness of the president, Mrs. Dean H. Le Favor, Mrs. Ziccardi will preside at the remainder of the meetings this year.

It was unanimously voted to make Mrs. Nathan Thorne of Moorestown an honorary member of the auxiliary. Mrs. Thorne has been a member of the organization for many years and her husband has recently retired from active practice.

Following the transfer of Dr. Hammel P. Shipps to the Camden County Medical Society, Mrs. Shipps resigned to become a member of the auxiliary of that county.

There was considerable discussion of bills to be presented before congress. A committee was appointed to study and report on all recent medical legislation both national and state.

It has been the custom of this auxiliary to give a scholarship to a member of the graduating class of one of the high schools throughout the county. This scholarship is to a school of nursing for a period of three years. A very favorable report was received from Pennsylvania Hospital School of Nursing, Philadelphia, Penna., on the student who entered the September class.

Plans were made to entertain the wives of eleven new members of the *Burlington County Medical Society* at a Christmas party at the home of Mrs. Gerald McDonnel.

At the conclusion of the meeting refreshments were served by the hostess.

Essex County

Mrs. Ames L. Filippone,
Chairman, Press and Publicity

A most successful and delightful luncheon-meeting opened the season's activities on October 28, 1946, at the Academy of Medicine in Newark. Sixty-five members attended.

Mrs. Frank S. Forte presided at the business session which was followed by luncheon for members and guests of honor. Miss Elsa Moegle, concert harpist, rendered numerous selections. After a cordial greeting from our president Mrs. F. S. Forte, our program chairman, Mrs. Don Caldwell, introduced the several speakers.

Dr. Thomas W. Harvey Jr., president of the Essex County Medical Society, urged members to obtain and study carefully the very complicated bill for discussion with their husbands. Dr. Harvey said the Smith-Ball-Taft bill was better than the Murray-Wagner-Dingell bill.

Dr. Joseph I. Echikson, president of the Academy, spoke of the tremendous research in cancer and the progress made to date.

Dr. Harrold A. Murray, president-elect of the Essex County Medical Society, praised the work done by the Auxiliary.

Mrs. Frederick G. Wandall, president of the Auxiliary to the Medical Society of New Jersey, commended the outstanding work done by the Auxiliary (which is the largest in the state) and urged an ever-vigilant watch for any legal measure bearing on the medical profession.

Mrs. Lodovico Mancusi-Ungaro, president-elect of the Auxiliary to The Medical Society of New Jersey, graciously acknowledged the greeting from the members.

On November 6, the Auxiliary held its first post-war supper-dance at the Brook in Summit. The tireless efforts of Mrs. Otto Matheke Jr., chairman, assisted by Mrs. W. A. Berger, made this one of the most enjoyable parties. About three hundred members and friends attended. The proceeds will go to the Benevolent Fund. Congratulations galore to Mrs. Matheke, Mrs. Berger and the capable committee for the excellent outcome! Dr. Murray rose to new heights as master of ceremonies on this happy occasion.

Another meeting was held in the Academy of Medicine on November 25, 1946. On this occasion, Mrs. Theodore Robie spoke on "Timely Legislation" a vital and important subject to all. As an added attraction, Mrs. Don Caldwell presented Miss Helen G. Metzler, noted lecturer on Current Broadway plays. Her subject was *Broadway on Parade,* and a most instructive and entertaining talk it was.

Gloucester County

Mrs. Joseph F. Hughes,
Chairman, Press and Publicity

In place of the regular monthly meeting, a tea was given by the*Woman's Auxiliary to the Gloucester County Medical Society,* on Thursday, November 21, in honor of Mrs. F. G. Wandall, of Clayton, president of the Woman's Auxiliary to The Medical Society of New Jersey. The tea was held at the home of Mrs. B. A. Livengood, of Woodbury.

Mrs. C. A. Bowersox, of Woodbury, president of the County Auxiliary, received with Mrs. Wandall, Mrs. C. I. Ulmer, of Gibbstown, state corresponding secretary, and Mrs. R. K. Hollinshed, of Westville, poured. Among the state auxiliary officers present were Mrs. W. E. Dodd, of Beach Haven, state president last year, Mrs. T. P. McConaghy, of Camden, state treasurer; Mrs. O. R. Carlander, of Audubon, state organization chairman,

and Mrs. T. H. McGlade, of West Collingswood, state public relations chairman.

During the course of the afternoon, Mrs. H. L. Sinexon, of Paulsboro, accompanied by Mrs. Miller, sang two selections. Following Mrs. Sinexon's beautiful rendition of *None But the Lonely Heart* and *I Passed by Your Window,* Mrs. Ulmer presented Mrs. Wandall with a pair of sterling silver candlesticks.

On behalf of the Woman's Auxiliary to the Gloucester County Medical Society, Mrs. Ulmer told Mrs. Wandall of the affection and esteem in which she is held by the doctors' wives of Gloucester County, in particular, and of their admiration for her excellent ability as president of the Woman's Auxiliary to The Medical Society of New Jersey.

Hudson County

Mrs. Sydney Chayes,
Chairman, Press and Publicity

A Christmas Party was given on December 2 by the members of the *Woman's Auxiliary to the Hudson County Medical Society,* following a short business session held in the Young Woman's Christian Association 270 Fairmount avenue, Jersey City. Mrs. Edward Murphy, president, presided.

Individual tea tables decorated with Christmas greens and the Yule logs burning in the fireplace made an appropriate background for Christmas songs and poems by Mr. Richard Nevin. Mrs. Robert Beatus, accompanied on the piano by Mrs. Edward Fleckenstein, sang several selections.

Tea was served with Mrs. Miles Long and Mrs. Abraham Jaffin, pouring.

The Auxiliary is sponsoring an essay contest known as the Friele Memorial Prize. All high school seniors in Hudson County are urged to participate.

The subject of the essay will be *Cancer.* This topic is to be presented in a manner that would stimulate lay interest in this important public health problem.

Mercer County

Mrs. Joseph R. Burns,
Chairman, Press and Publicity

On Monday, December 9, at 2 o'clock, Mrs. Ernest Purcell, president of the *Woman's Auxiliary to the Mercer County Medical Society* presided over an interesting meeting held at the Medical Society building. Many old and new members attended in response to the membership campaign, under the chairmanship of Mrs. George Haggerty and Mrs. William McCarthy.

It was proposed that one Monday afternoon a month, begininng January 20, be devoted to making dressings for cancer patients under the supervision of Mrs. Thomas Murto.

A letter was read from Mrs. Mary Roebling, requesting the purchase of Christmas gifts for eight patients at Donnelly Memorial Hospital.

Under the able direction of Mrs. Chester Chianese, two movies, "What Price Happiness", and "Home Safe Home" lent through the courtesy of the Women's Division, New Safety Council, were shown.

Master Tommy Madden again acted as Santa Claus and distributed the exchange gifts.

Tea was poured by Mrs. George N. J. Sommer. Mrs. H. Donald Cowlbeck, the hostess, was assisted by Mrs. Robert Applestein, Mrs. Charles Cohan, Mrs. Dunbar Hutchinson, Mrs. William McCarthy, Mrs. Thomas Murto, Mrs. Floyd Hunter, and Mrs. Joseph R. Burns.

Middlesex County

Mrs. Norman Rosenberg,
Chairman, Press and Publicity

Mrs. Ralph J. Faulkingham, 61 Livingston avenue, New Brunswick, was hostess to the *Woman's Auxiliary to the Middlesex County Medical Society* at its annual Christmas Party on Wednesday evening, December 18. There was a Christmas gift exchange to which each member brought a wrapped article for the grab bag.

Monmouth County

Mrs. Joseph E. Bossone

The *Woman's Auxiliary to The Monmouth County Medical Society* met at a luncheon at The Colony in Rumson. Mrs. Anthony Perrotto was hostess for November. Guest speaker was Mrs. Frederick G. Wandall, president of the state auxiliary, who spoke on relation with our Medical Society.

A committee was formed to investigate needy families for Christmas stockings.

The Blood Bank reported progress in obtaining donors.

The December luncheon meeting will be held in Long Branch, with Mrs. Armond Mazzi hostess.

ROLL CALL OF EVENTS

Atlantic County—The Auxiliary met on January 10, at the Traymore Hotel. Mrs. Edward H. Dyer, chairman for the evening implemented plans for a safety program in the form of a movie.

Burlington County—A tea was held January 6, to honor the past presidents, at the Zurbrugg Memorial Hospital, Riverside.

Camden County—On January 7, 1947, Dr. Ivor Griffith, president of the Philadelphia College of Pharmacy was guest speaker. The musical program was in charge of Mrs. Robert Kurtz of Merchantville.

Essex County—A meeting will be held January 27, 1947, at the Academy of Medicine, Newark. Karl H. Platzer, Ph.D. Consulting Psychologist, will speak.

Middlesex County—There will be a round-table discussion of medical legislation at the home of Mrs. S. Goldman in New Brunswick. Mrs. S. Miller, Legislative Chairman, will be in charge of the program.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **January, 1947** **No. 1**

PULMONARY tuberculosis is a disease of uncertainty, with periods of quiescence and of reactivation. While many individuals recover spontaneously, in others the disease may progress notwithstanding all manner of treatment. For many, recovery depends upon the knowledge and the facilities for properly adjusting the mode of life to the disease. This adjustment is best carried out under the watchful eye of the physician.

THE IMPORTANCE OF POSTSANATORIUM CARE OF THE TUBERCULOUS

One of the great dangers to the individual with tuberculosis is that the disease may advance considerably without the patient's being aware of it. For this reason it is essential that the pulmonary condition be observed periodically by means of properly taken X-ray films.

The education of the patient is one of the principal aims of sanatorium care. The knowledge of the disease, the reasons for making adjustments in living, working and in environment, the patient's part in recovery and its maintenance, all furnish the background for his care after leaving the sanatorium. Even after discharge, his disease is still a serious potential danger to himself and to his associates.

Early in sanatorium treatment, if it is possible, it must be determined to what extent the patient will be able to return to his former work and life. If he cannot assume the so-called "normal life," efforts should be made to fit him for work suitable to his condition. Recreational therapy, occupational therapy, rehabilitation and the establishment of work tolerance should go hand in hand with the general treatment. Ideally the sanatorium should conduct its physically able patients through all the stages of rehabilitation until a work tolerance of eight hours has been reached. Others should be brought to their maximum work tolerance and be put on part-time work.

The two most satisfactory guides for determining the patient's condition are the X-ray film and the patient's temperature. Of these, serial X-ray films tell us more completely the dynamic state of the disease. When the X-ray films show marked changes for better or worse, the disease is active, retrogressively or progressively, and rest in bed is indicated. Such is the case, too, when elevation of temperature not due to other causes is present or there is loss of weight, loss of appetite, or fatigue. Te determine the status of the disease, the patient should take his temperature and pulse at about 4:00 p. m. and 8:00 p. m., and keep a record of it as well as of any toxic symptoms. At least once in six weeks he should have an X-ray examination of his chest. In old chronic disease the interval may be lengthened. With such a record the physician is in a position to judge the reaction of the patient to his disease and to modify treatment as needed.

Each patient is an individual and requires individual treatment. As a general rule, after the X-ray films have revealed a practically stationary lesion for several months, and there are no toxic symptoms, the patient may become partly ambulatory. Attention should be paid to the state of his nutrition, and he should avoid overheated stuffy rooms at all times.

Life in a sanatorium is much less exacting than life at home. To have attained an arrest of the disease in the sanatorium does not mean that the arrest will continue under adverse environmental and nutritional conditions outside.

Essentially, tuberculosis is a chronic disease; in such a disease education in how to live with it and remain well is of extreme importance. Continuous readjustments should be made by a physician who

knows the picture as a whole. To be successful, the treatment of tuberculosis must go on long after discharge from the sanatorium.

What the sanatorium does or can do for a patient is briefly outlined because postsanatorium care and complete rehabilitation are but an extension of the sanatorium activities. Vigilance should be the keynote of this extended period, vigilance on the part of the patient and on the part of his physician.

One can give no fixed procedure for subsequent observations of the discharged sanatorium patient. For those whose disease is arrested an X-ray examination every six months for two years probably would be sufficient, providing the patient feels well and has no symptoms. Those discharged as apparently arrested probably should have X-ray examinations every three months for one year and after that at longer intervals if all goes well. At the time the X-ray examination is made there should be a consultation with the tuberculosis physician during which advisable adjustments in the routine of the patient may be recommended.

For many years the Trudeau Sanatorium has made an effort to find out what happens to its discharged patients. Once each year, in the anniversary month of his discharge, the patient is sent a blank to fill in. In addition to a request for notice of change in address the patient is asked about his health in detail, his work and his earning capacity. This inquiry reminds the patient of the importance of a check-up of his condition. Replies are received from about 90% of former patients.

In this institution the sanatorium staff is always glad to advise the patient when requested and they welcome opportunities to cooperate with outside physicians. The staff gladly examines the patient's chest films at the request of his physician and he is told that he may return to the sanatorium at any time for a check-up. Such a check-up affords an opportunity for the attending physician to utilize the specialized services of the sanatorium staff which is more important if he is not specially trained in tuberculosis. It is the essence of teamwork that the physician attending the patient be kept fully informed about the findings and recommendations of the sanatorium staff.

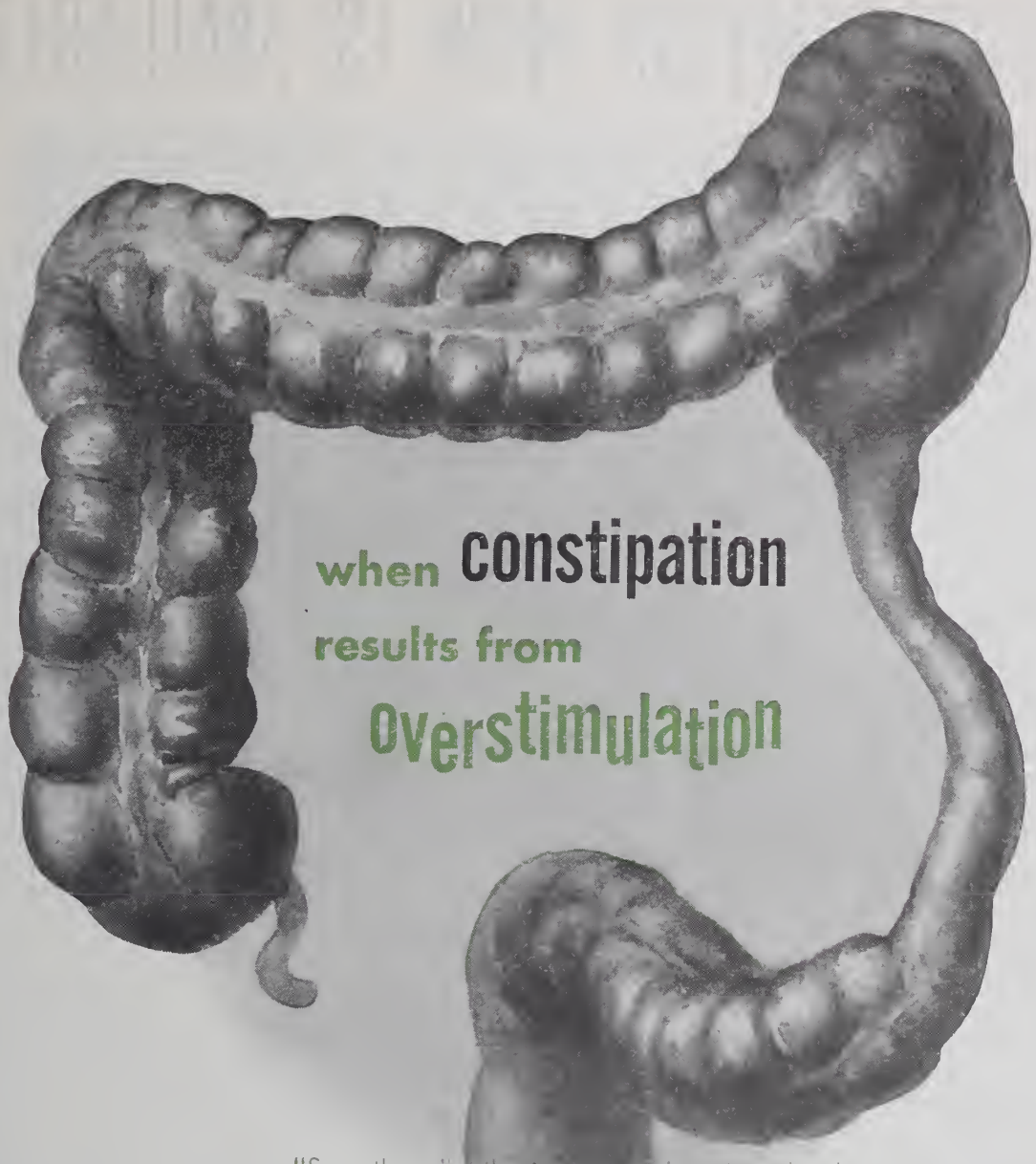
The treatment of tuberculosis should be carried on over many years, even if there has been an apparent restoration of health. A knowledge of tuberculosis and its many and varied behaviors is needed by him who would carry out such treatment with skill. It must be recognized that in all cases the X-ray gives the most accurate estimate of what is going on in the lungs. The sanatorium lays the preliminary groundwork in education and provides satisfactory environmental and nutritional standards, but the treatment must go on long after the patient has been discharged. Prevention of relapse is of greater importance than treatment after relapse has occurred.

The Importance of Postsanatorium Care of the Tuberculous, Fred H. Heise, M.D., American Review of Tuberculosis, October-November, 1946.

SUPPLIED BY

New Jersey Tuberculosis League

15 East Kinney Street, Newark 2, New Jersey



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Ps. aeruginosa
(*B. pyocyaneus*)

Klebsiella pneumoniae
(*Friedländer's bacillus*)

TULAREMIA

All *H. influenzae* infections

Streptomycin is a helpful agent also in the treatment of the following diseases, but its position has not been clearly defined:



Tuberculosis.

Peritonitis due to susceptible organisms.

Pneumonia due to *Klebsiella pneumoniae* (*Friedländer's bacillus*).

Liver abscesses due to streptomycin-sensitive bacilli.

Cholangitis due to susceptible pathogens.

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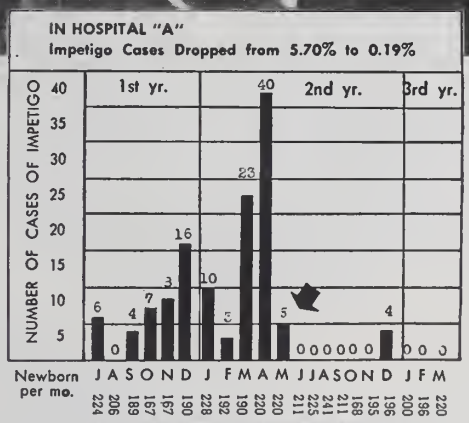
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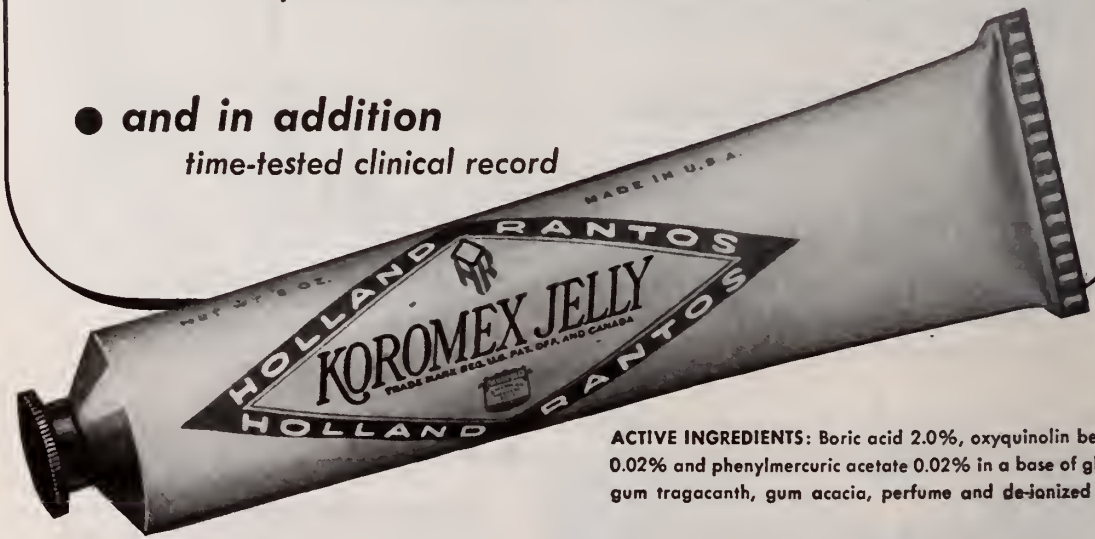


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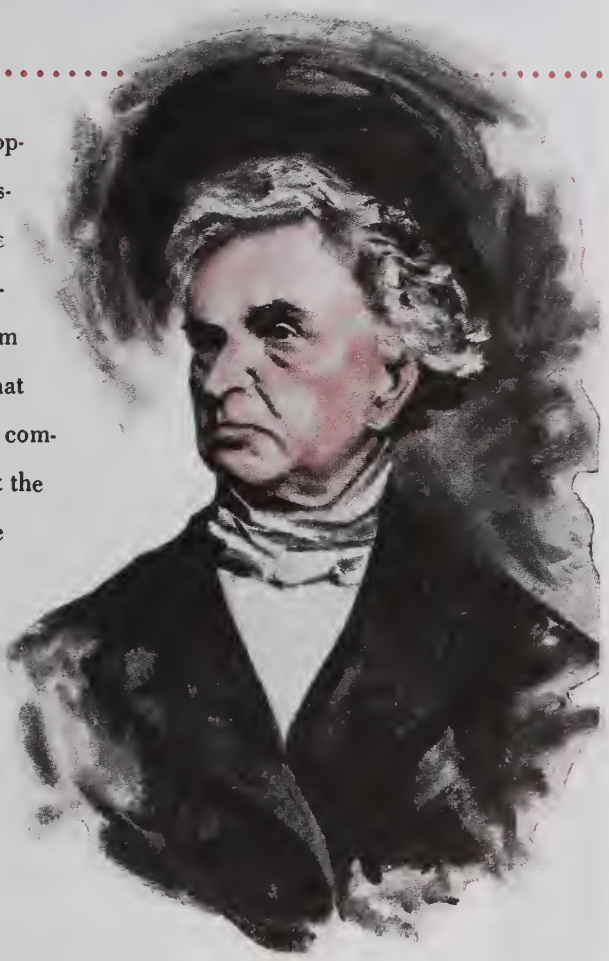
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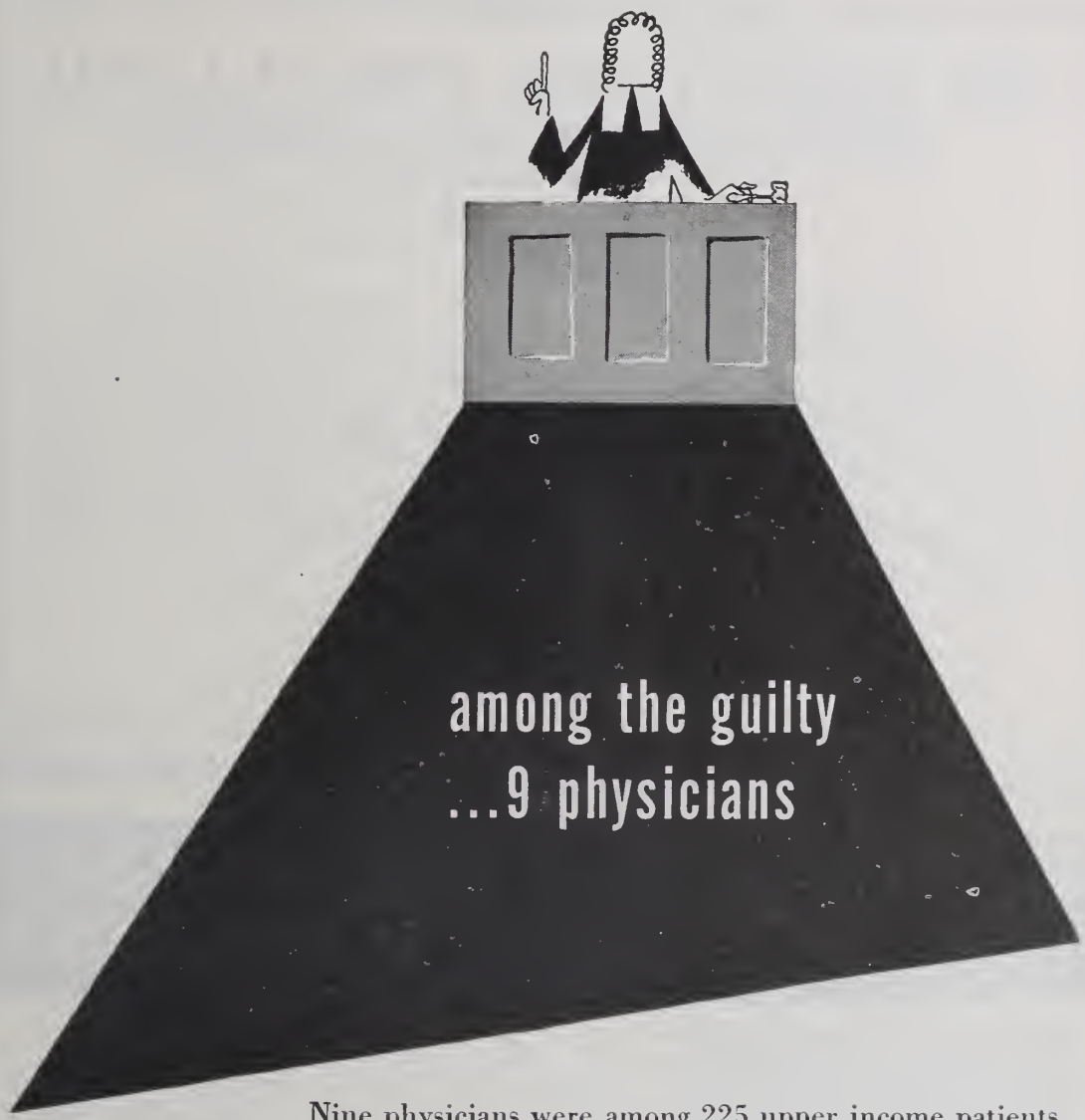
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1. New England J. Med. 228:118 (Jan. 28) 1943.
2. J. A. M. A. 129:613 (Oct. 27) 1945.

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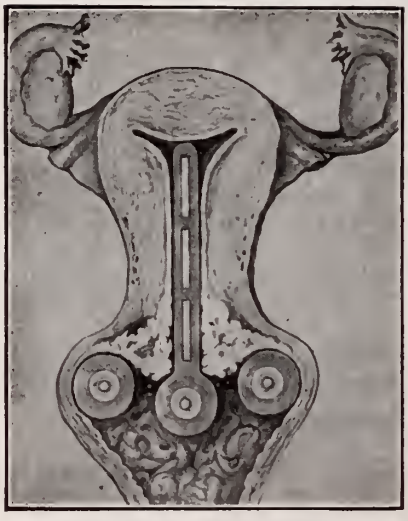
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. Russell, H.G.B., abstracted, Proc. Roy. Soc. Med. 36:401.



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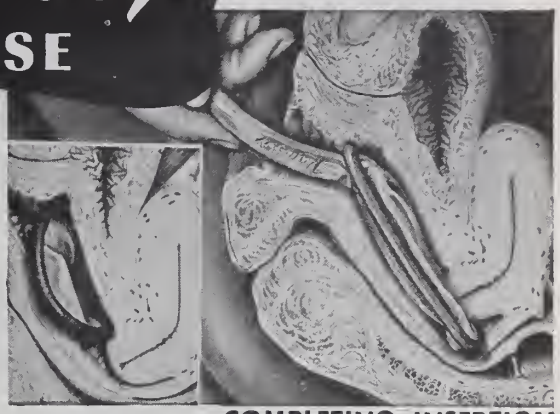
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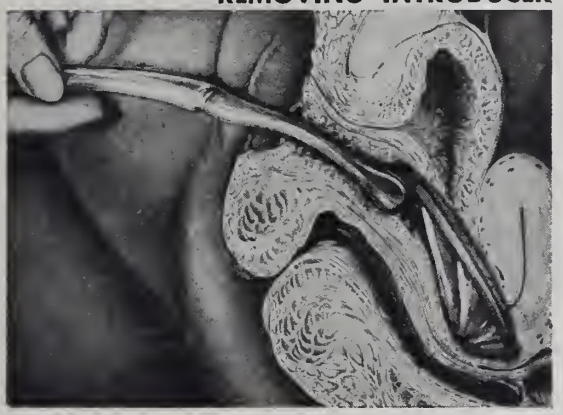


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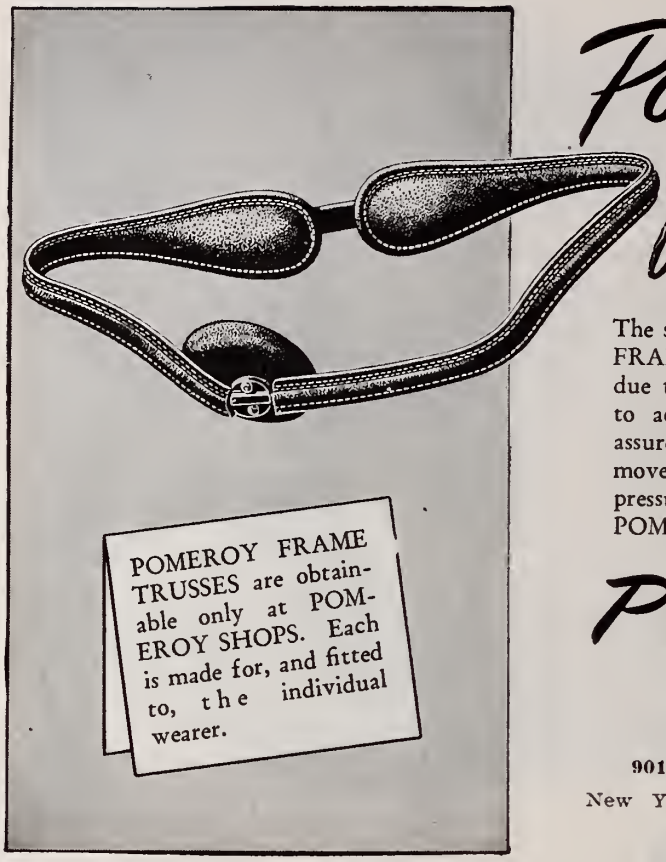
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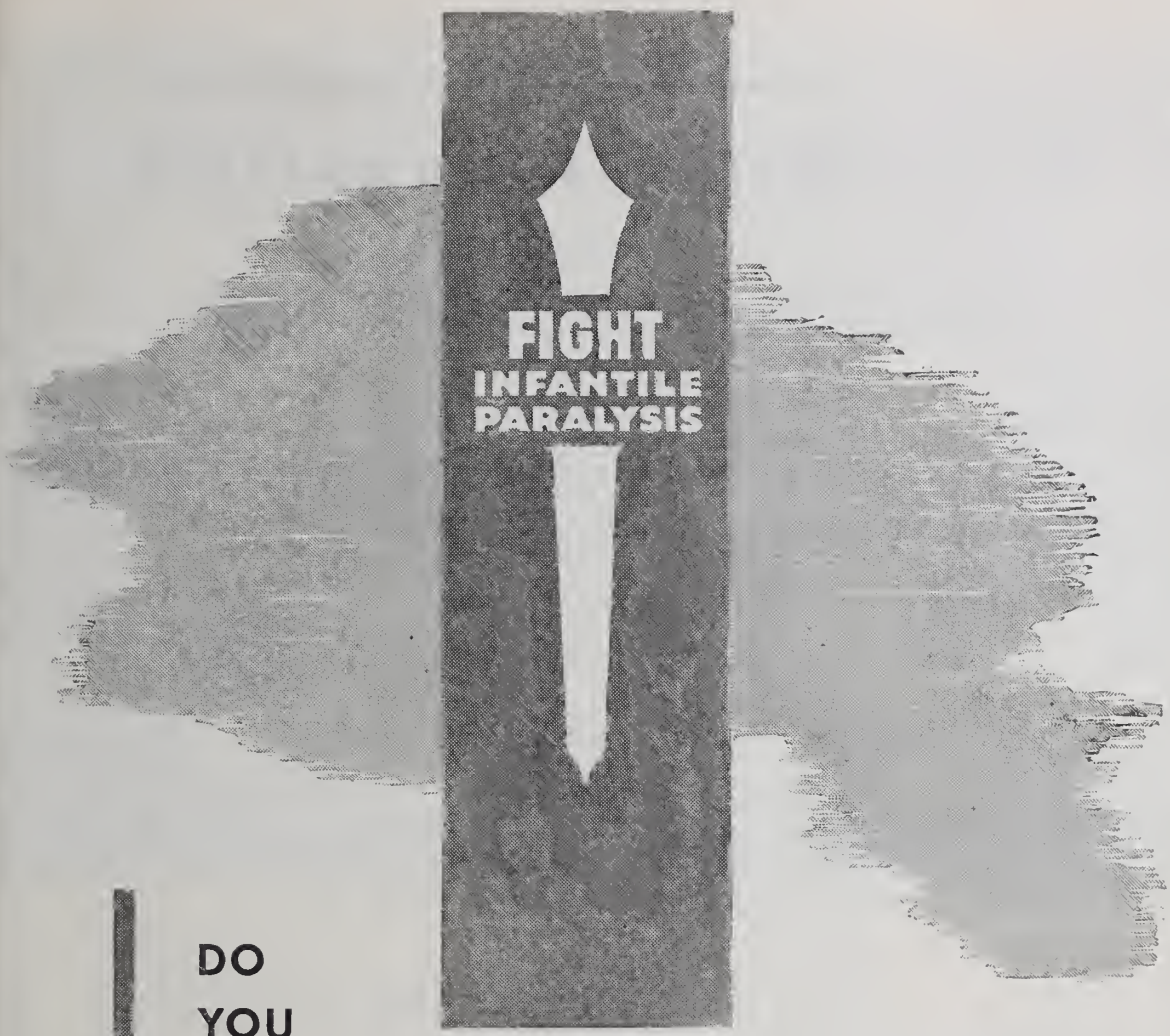
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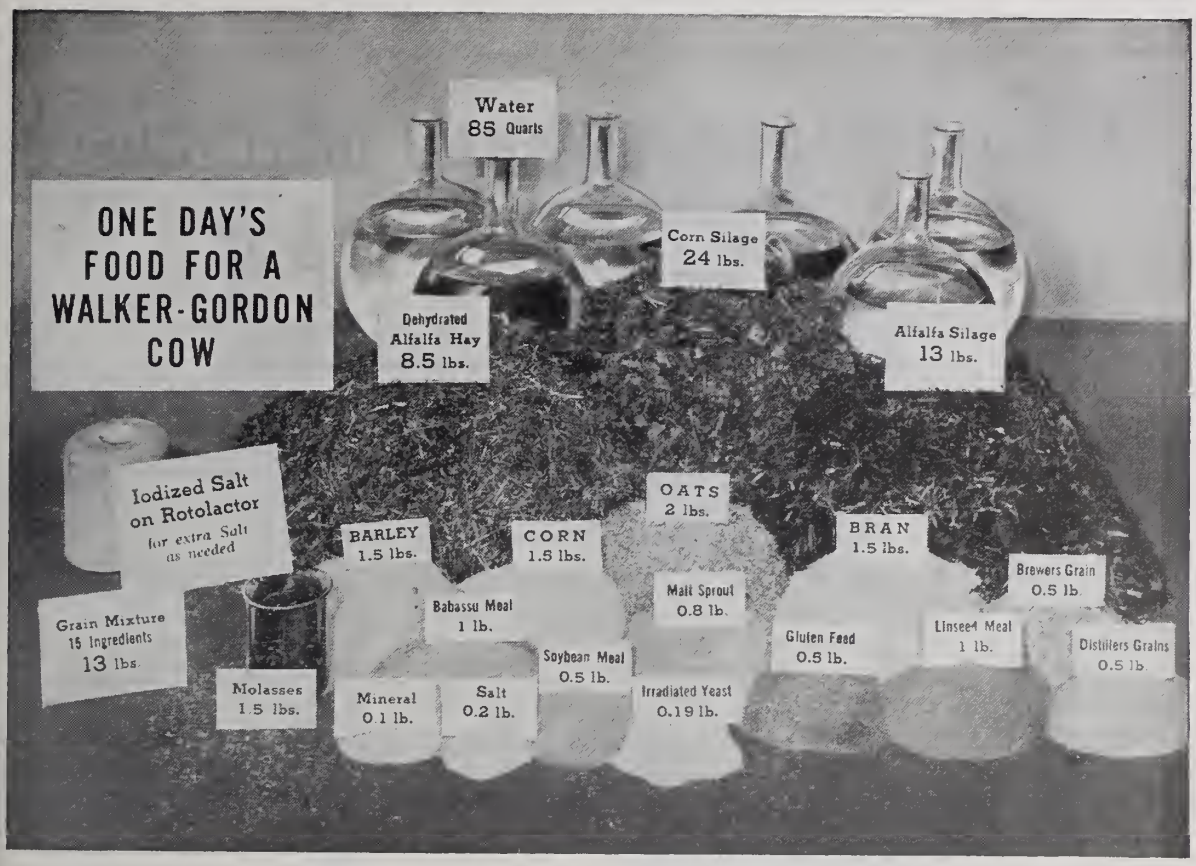
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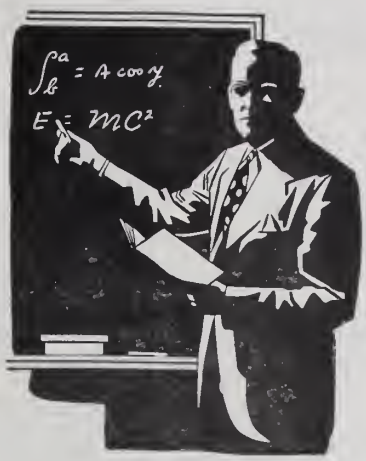
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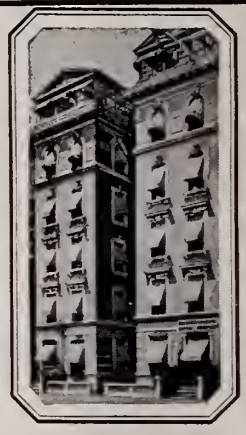
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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



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OF

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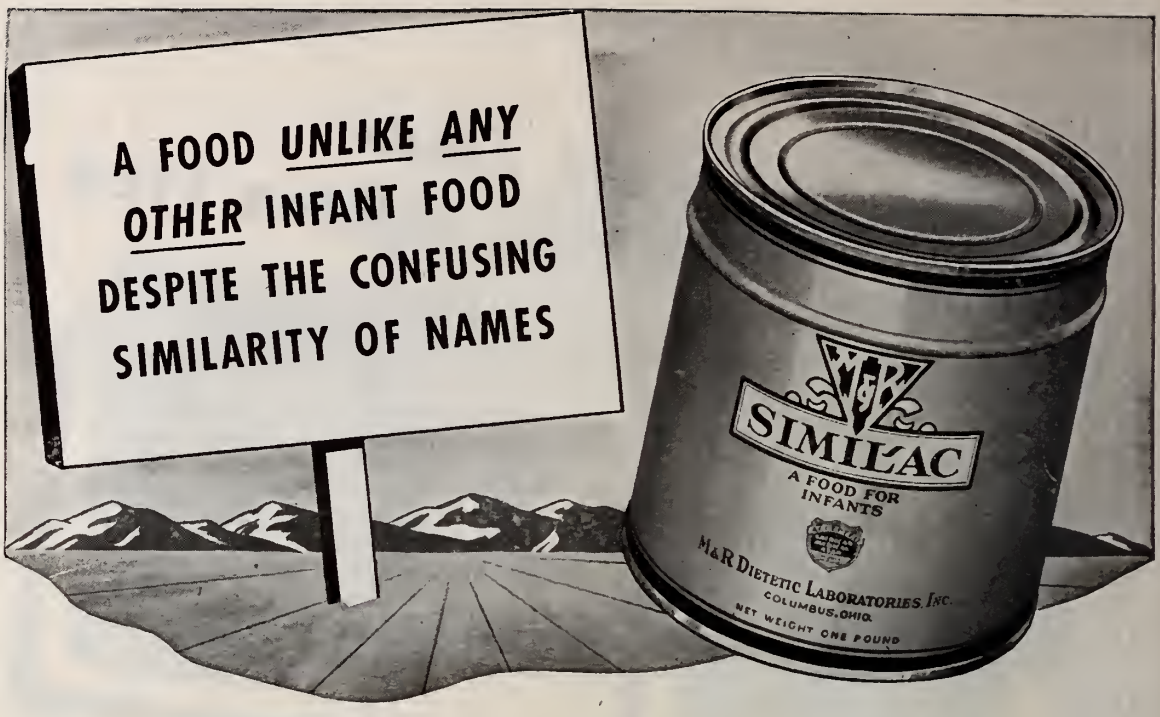
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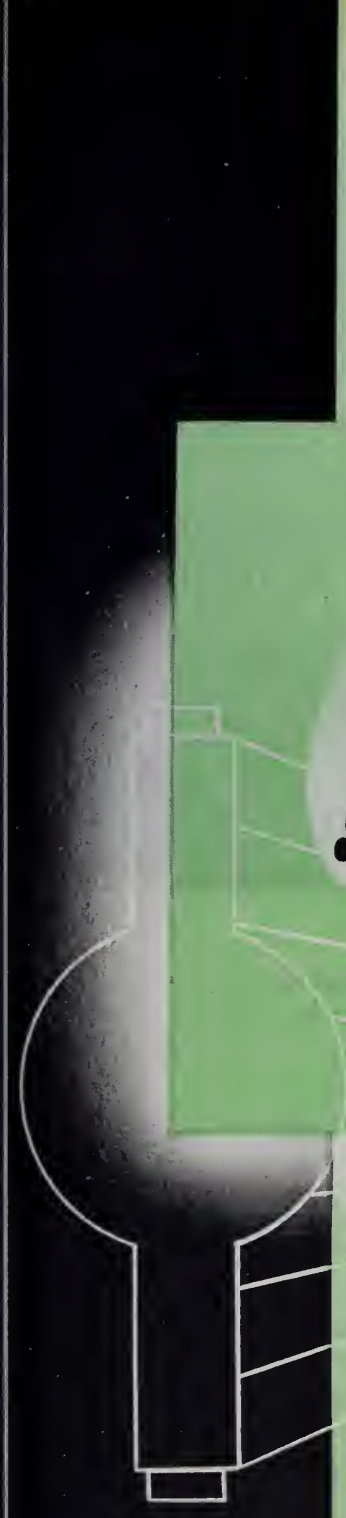
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1. Dickinson, R. L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
2. Eastman, N. J., and Scott, A. B.: Human Fertility 9:33 (June) 1944.
3. Warner, M. P.: J. A. M. A. 115:279 (July 27) 1940.

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N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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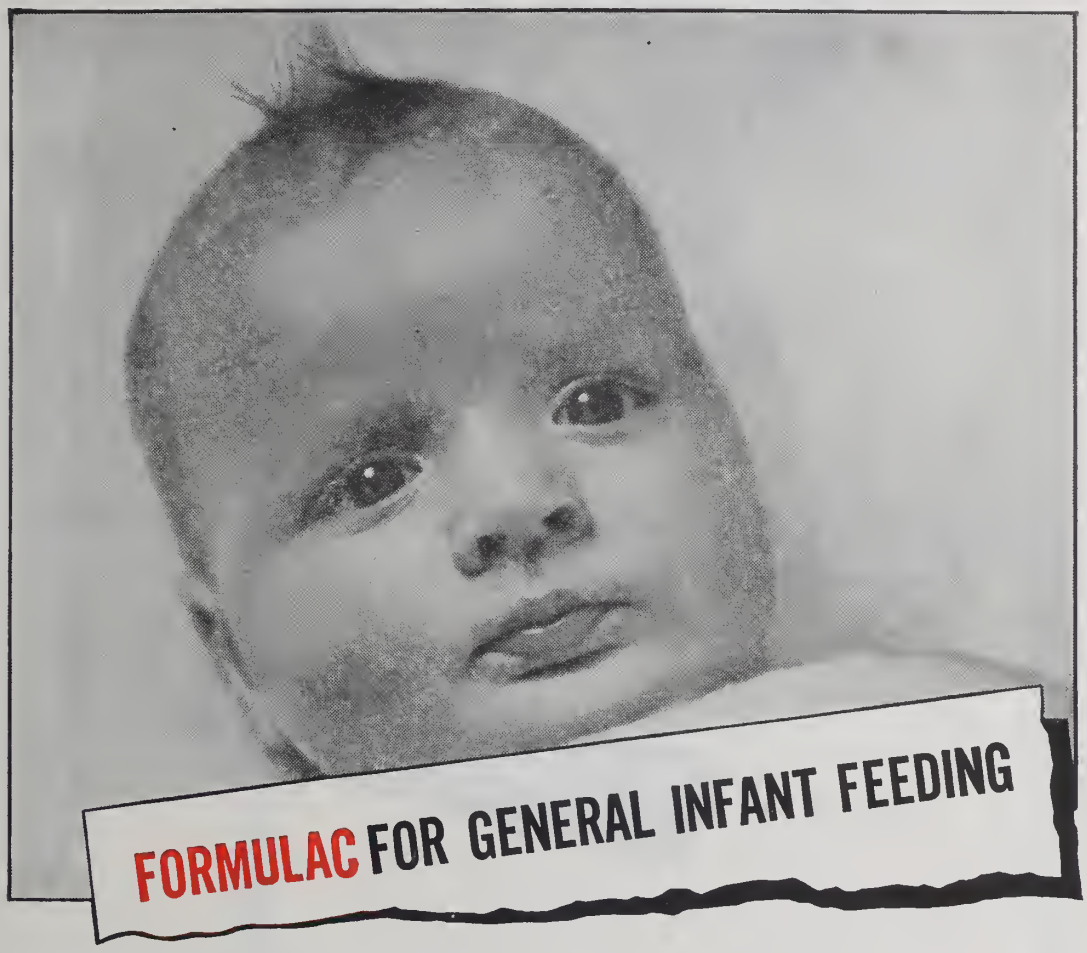
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Cawthorne, T.: The Treatment of the Common Cold, Clin. Sup. to King's College Hosp. Gaz. 18:111.

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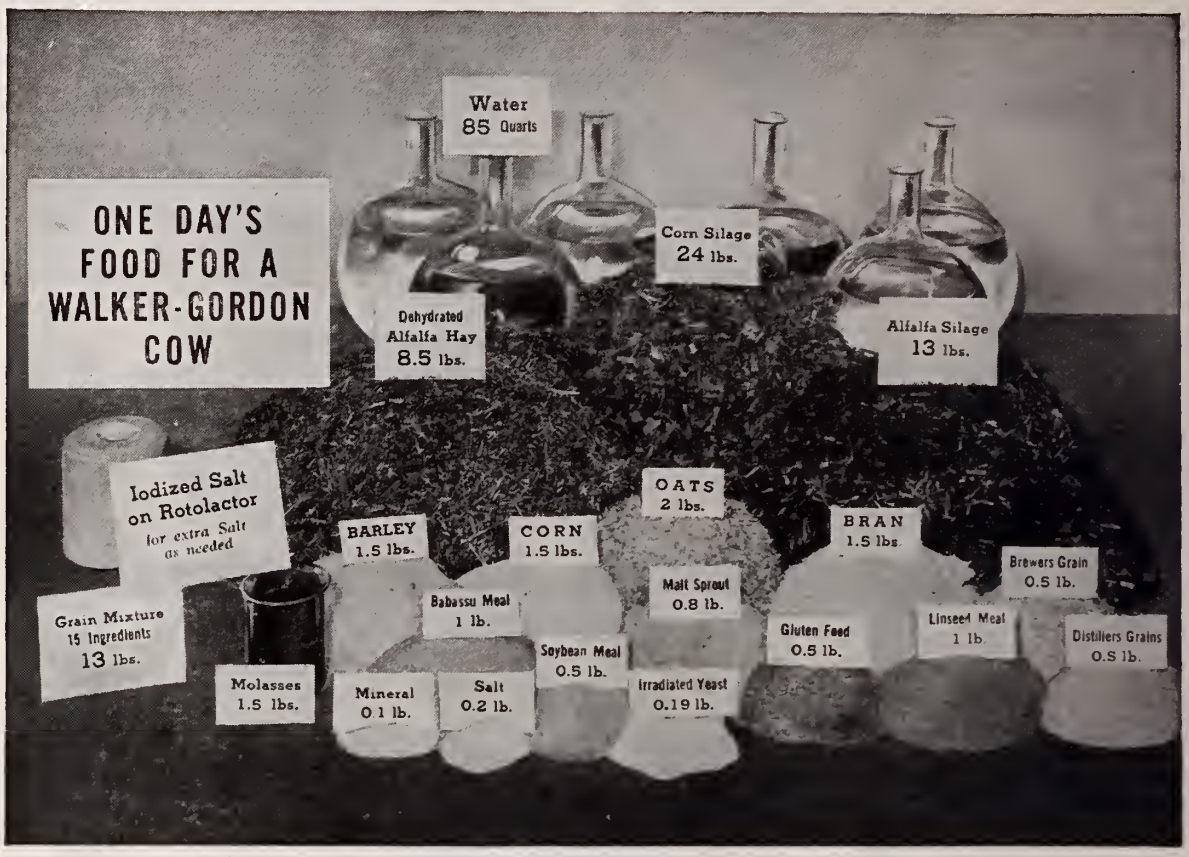
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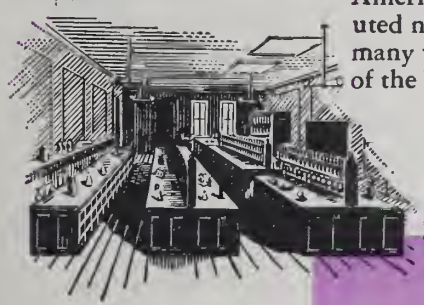
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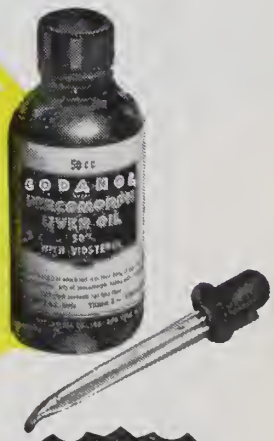
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[1]Jeons, P. C.: Hondbook of Nutrition, Chicogo, A.M.A., 1943, p. 356.

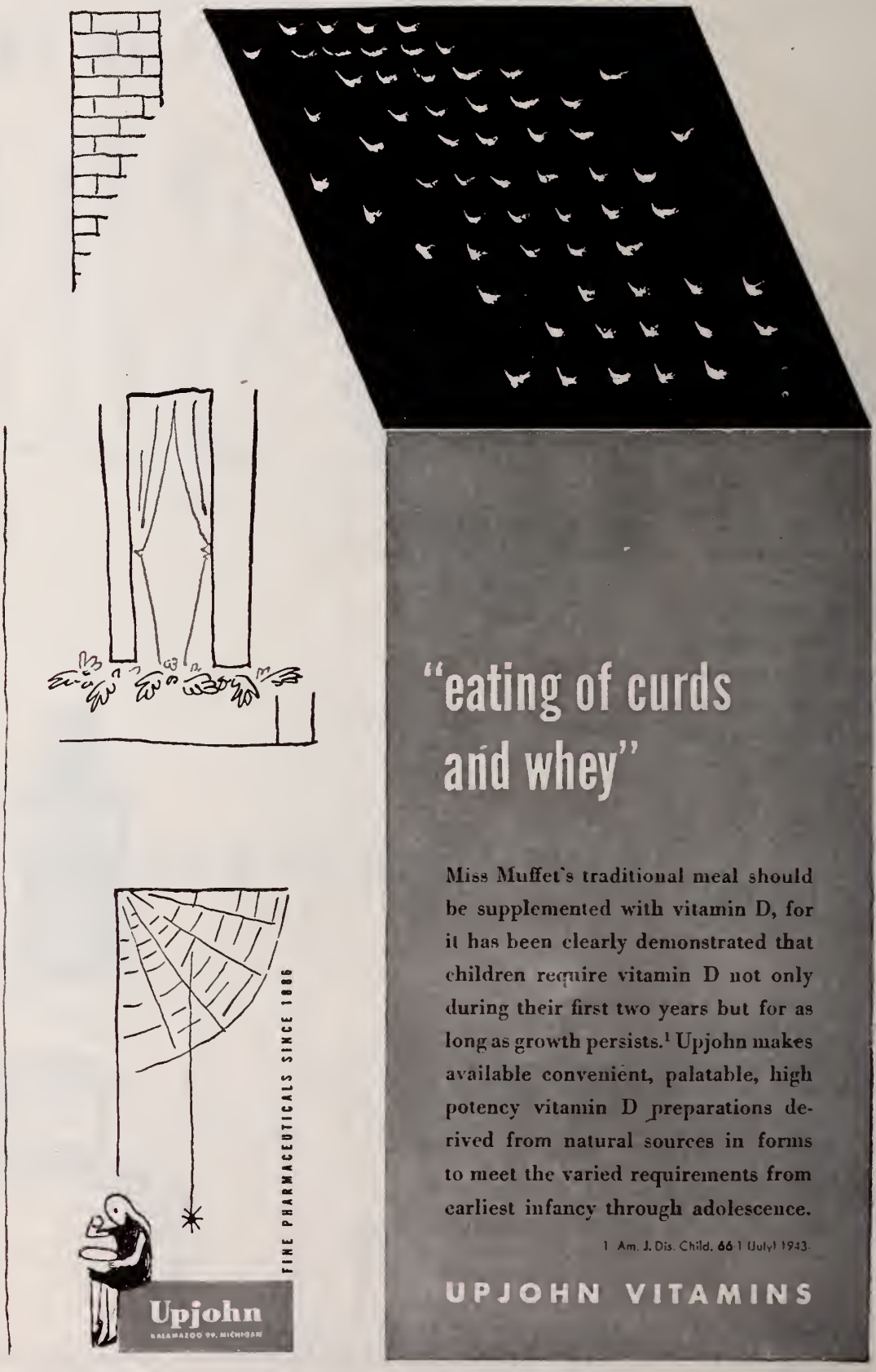

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1 Am. J. Dis. Child. 66:1 (July) 1943.
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Volume 44
Number 2

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OF
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THE PRIVATE OFFICE AS A HEALTH CENTER

If the general practitioner is unwilling or unable to do a health maintenance examination, the patient will perforce go to a clinic which has announced such a service. There has been much publicity lately on the importance of general physical examinations in the detection of cancer and in the maintenance of health. When a New York tabloid featured the opening of the Strang Clinic in New York, a flood of letters and calls poured in, and already that clinic is now booked until November 1947. Many of these applicants were willing and able to pay their private doctors for this kind of service. How many of their doctors were willing and able to render this service? The cry that the operation of such a clinic, (whether designated a cancer prevention or a health maintenance agency) is a blow to individualized medicine, is constantly heard. It is fair to ask the complaining doctors if they are prepared to give their patients an equivalent service.

We frown on hospitals, agencies and clinics which do general physical examinations at cut rates because we see such activities as steps away from free choice, as examples of the corporate practice of medicine and as devices to cheapen the value of examinations. Our frowns will retain no patients however; our willingness to provide thorough diagnostic facilities in the office will.

At the moment, the best approach to health maintenance examinations is by way of "cancer prevention". This is a dramatic, attention-arresting, and important basis on which to offer such a service. It goes without saying that the practitioner will really do a thorough study including vaginal and rectal examinations and a flat chest plate. As a practical suggestion, the doctor might send to AMA headquarters for the excellent and useful *Physical Examination Blank* printed there. For the small sum of a dollar and fifty cents, the practi-

tioner can have two hundred of these forms. If every suggested question is asked and every blank on the form filled in, the doctor will get an exhaustive overall understanding of his patient's status. The suggested examination procedures are within the skills and equipment of the general practitioner.

Patients have learned that a good physical examination including the history (and the drawing of specimens for blood count, urine analysis, blood serology) will take at least forty-five minutes. They will not be satisfied with anything more cursory. The doctor who is not prepared to devote the time and attention which this requires should send the patient to a colleague who is. If he fails to do either, let him not be surprised if the patient goes to a publicized health maintenance or cancer prevention clinic and gets a work-up at a reduced fee.

Follow-up is important, and doctors need no longer be deterred by fear that the patient will think he is trying to make an unnecessary fee. If, for example, a small mass is found, and biopsy does not seem indicated, a follow-up visit a few weeks later to see if the mass has grown, is sensible and the patient knows it is.

The demand for group medicine, for more clinics, for new health centers and the like is growing rapidly. A stand at this point, by offering complete diagnostic service, is the family doctor's chance to retain medical practice in its individualistic framework. It is, perhaps, his last chance.

OUR DEBT TO THE DRUG INDUSTRY

Few practitioners realize the debt of organized medicine to the American pharmaceutical industry. It is not just a matter of their maintaining a constant flow of educational literature or of the helpful visits of the detail man. It is the drug industry which makes our annual meetings possible. For their rental of exhibit booths supplies the financial fuel which makes our medical conventions as large, as successful and as instructive as they are. Their advertisements in this and in all medical journals are sufficient to pay for the printing of the scientific articles and society news which make up the meat of our periodicals.

Most of the great advances in modern drug therapy have come from the laboratories of American pharmaceutical houses. To be sure, the industry engages in scientific research (or finances research elsewhere) with the ultimate aim of producing marketable drugs. But the effect of this impulse is to provide the impetus, the tools, the methodology and the money for scientific study which ultimately give doctors finer and finer weapons in their struggle with disease. The freedom of private pharmaceutical companies to engage in this research and the competitive nature of the industry have jointly worked to the betterment of the profession and the public.

We can judge only by results, and in terms of the discovery, development, and distribution of new and better pharmaceuticals, America now leads the world. The drug industry has long been an indispensable partner in the doctor's work; perhaps it has too long been only a silent partner. The profession has a genuine debt here, and one that is accepted too casually and acknowledged too rarely.

ORIGINAL ARTICLES

THE CANCER PROGRAM IN NEW JERSEY

PART II—A STATE-WIDE TISSUE DIAGNOSTIC SERVICE

Prepared by the Advisory Committee on Cancer Control,*
The Medical Society of New Jersey

Early diagnosis is the key to successful management of cancer. Early diagnosis is predicated on the development of a high index of suspicion in conjunction with a thorough history and complete physical examination.

In many instances, where clinical diagnosis is difficult or doubtful, a biopsy is the procedure which removes doubt, leads to and offers the greatest opportunity for the successful treatment of the lesion.

Biopsy—the removal of small portions of suspected tissue for microscopic examination—is a procedure of the greatest value and importance in the cancer control program. The plan outlined here for a state-wide Tissue Diagnostic Service, places at the disposal of every physician in New Jersey a very important aid in his work of cancer diagnosis.

THE GENERAL PRACTITIONER'S OPPORTUNITY

General practitioners have the greatest opportunity for discovering early cancer; they see more patients than all the hospital clinics combined.

The biopsy service can be a valuable adjunct to the office practice of every general practitioner and specialist whether they practice in urban or rural areas.

FOLLOW-UP AT REGULAR INTERVALS

Cancer is the great masquerader of the day. It must be suspected before it can be detected. An apparently inocuous small tumor mass today, can change in its pathologic character in a matter of weeks, hence the necessity for follow-up of a patient at regular intervals, with a careful record of the *exact size* of the mass in terms of centimeters or inches. Do not record it as a "small mass" or even as "mass, the size of a quarter."

It is equally important to impress on the patient the importance of returning for a check-up on a given date rather than giving the admonition to "drop in if it bothers you."

It is obviously far better to have a suspicion of cancer and upon recheck and examination find it groundless, than harbor the suspicion, (or worse yet ignore the possibility) until the suspicion has become a certainty and delay may have caused the spread of the disease with consequent increase in the difficulties of treatment.

TISSUE DIAGNOSTIC SERVICES

The present plan was developed as a result of conferences between representatives of the Board of Trustees, The Medical Society of New Jersey, and representatives of the other interested agencies.

The plan is predicated on the following agreement:

1. Members of the New Jersey Society of Clinical Pathologists and other recognized pathologists will provide the diagnostic skills.

2. Physicians desiring to avail themselves of this service, will send tissue specimens to the pathologist of their choice. These specimens are to be submitted in containers to be furnished, accompanied by a standard report form giving the necessary clinical data regarding the patient, the patient's economic status and other pertinent medical and personal information.

   Tissue specimens taken by private practitioners from their indigent patients attended privately, not in hospital clinics, will be processed and diagnosed gratis. The pathologist's customary fee will be charged all other patients.

3. This is a voluntary agreement; nothing herein shall be construed to apply to or mean a change in any present tissue diagnostic service in hospitals and clinics, private or public, throughout New Jersey.

4. The American Cancer Society, New Jersey Division, Inc., will provide the necessary number of containers, suitable for the mailing of tissue specimens by private physicians to pathologists of their choice.

* The committee consists of Doctors W. O. Wuester (Chairman), O. R. Holters, J. I. Echikson, H. W. Jack, J. H. Kler, T. B. Lee, W. J. Marquis and Leonid S Snegireff.

The specimen containers include the necessary amount of fixative (10 per cent formalin); these will be distributed to private physicians throughout the state. The costs of such distribution to physicians will be borne by the American Cancer Society, New Jersey Division, Inc.

5. Any system for the reclaiming of containers for further use will be encouraged and, if practicable solution can be arrived at, may come within the scope of activities of the Field Army, American Cancer Society. Since containers cost 22 cents each, they should not be wasted.

According to this plan, all physicians in New Jersey will be circularized by a post card with a prepaid reply card, requesting that they indicate whether they desire to receive biopsy containers, and if so to state whether four or six such containers are desired.

Along with the containers there will be sent a card requiring the physician submitting biopsy specmens to fill in certain basic, pertinent data for the pathologist's information.

The American Cancer Society, New Jersey Division, Inc., has set aside five thousand dollars for the above project which includes purchase of containers; fixative; handling; mailing and printing costs.

Below is a sample of the instruction sheet and report form.

NEW JERSEY SOCIETY OF CLINICAL PATHOLOGISTS COOPERATES

Recognizing the importance of pathologic diagnosis in the management of cancer cases, the Executive Committee of the New Jersey Society of Clinical Pathologists adopted recommendations for the establishment of a cooperative program between that Society and the Division of Cancer Control in the State Department of Health at a meeting held in Newark in December 1946. This action of the Executive Committee was later approved by the members of the Society.

CANCER CONTROL ACTIVITIES

MEDICAL SOCIETY OF NEW JERSEY AND COOPERATING AGENCIES TISSUE DIAGNOSTIC SERVICE

All tissue specimens must be put immediately in glass containers furnished, and covered with 10% formalin solution supplied in the bottle. Labels on glass container should bear name of patient and attending physician.

The following data is to be furnished on the card:

Patient's Full Name..... Date.....

Address.....

Sex..... Age.....

Brief History with Clinical Impression

.....

.....

.....

.....

.....

Patient Status	*(Check)*
Private	
Indigent	

Name of Physician taking biopsy

.....

.....

Address

Exact Source of Specimens (Anatomic Site).....

Diagnosis of Pathologist.....

N. B. This card is for permanent record.

Please fill in all details. If necessary use reverse side for additional data.

.....

Signature of Pathologist

.....

Address

Designed to promote the scientific study of tumor pathology and to augment pathologic diagnostic services to the medical profession, the following recommendations for the joint program were adopted:

1. That the Society of Clinical Pathologists establish a tumor registry in cooperation with the Division of Cancer Control of the New Jersey Department of Health.

2. That such a tumor registry offer physical facilities for the collection and filing of cancer case histories, tissue slides, gross pathologic specimens and photographs of pathologic material; that it maintain library facilities, and keep other pertinent data related to tumor problems.

3. That cancer histories, tissue slides, and other data necessary for the maintenance of the registry be furnished by the members of the Society of Clinical Pathologists and other physicians, for permanent filing with the registry.

4. That the Division of Cancer Control of the State Health Department provide laboratory facilities for the preparation of gross pathologic specimens and microscopic sections for the tumor registry.

5. That the Division of Cancer Control of the State Health Department employ a competent pathologist (approved by the Consulting Board of the tumor registry) whose activities will be guided by the Consulting Board in so far as the work of the tumor registry is concerned.

6. That the Society of Clinical Pathologists select a consulting Board of Tissue Pathologists to direct the professional activities of the tumor registry in cooperation with the Division of Cancer Control State Health Department.

7. That the Chief of the Division of Cancer Control of the State Health Department be a member of the Consulting Board of the Society of Clinical Pathologists.

In order that the reader might have the benefit of the best thoughts on the subject of biopsy, detailed authoritative opinions are cited below.

IS BIOPSY A DANGEROUS PROCEDURE?

Biopsy has often been avoided because of the fear that the procedure itself might awaken a relatively quiescent growth to increased and undesirable activity. Theoretically, this is a reasonable assumption but practical experience shows conclusively that this possibility may be largely discounted and should not be the sole deciding factor governing the decision to take a biopsy. Even if such a possibility could be regarded as imminent, its implications may be eliminated in large measure by methods permitting the immediate examination of the removed tissue, concerning which more will be said later. The fear of increasing the activity of a malignant growth through biopsy should not be considered a contraindication, nor lead to neglect of this most important and valuable means of early diagnosis of cancer.

To this general rule there is, however, one proper exception, namely, sarcoma. As sarcomata are frequently highly vascular, and as they metastasize mainly by way of the blood stream, any procedure which tends to injure, disturb, or open up blood channels obviously increases the opportunity for metastasis and may even initiate such dissemination of the tumor by way of the circulation. This is particularly true of melanotic sarcoma which, because of its extraordinary tendency to explosive and fulminating metastasis, should never be subjected to biopsy.

The status of biopsy, in relation to its theoretical dangers, has been succinctly put by Eric Liljencrantz, M.D., in the Stanford University *Cancer Handbook*:*

"1. Whatever the theoretical dangers of biopsy may be, the dangers of attempting radical treatment of or abandoning a patient to a hopeless prognosis without tissue proof are far more serious.

"2. The dangers of biopsy and the time elapsing before starting treatment vary widely for various tumors. Tumors of breast, bone and thyroid should not be cut into or narrowly excised unless all preparations are made for examination of quick frozen sections and immediate radical operation.

"3. Biopsy of tumors of skin, lip, oropharynx, bladder, and uterus is less dangerous; but the minimum of time (a few days perhaps) should elapse before institution of treatment. Melanoma should never be cut into."

Properly performed biopsy is less dangerous

* (Cancer Handbook, Stanford University, p. 13).

than is rough handling or massage by patient or physician.

If fractionated courses of x-ray treatment are contemplated in treatment, biopsy may be taken after such treatment is well under way.

It must be recognized, however, that the effect of radiation, and especially of repeated radiation, upon tissue may definitely complicate, if it does not obscure, the interpretation of the microscopic picture and to this extent increase the difficulty of microscopic diagnosis.

Neither indiscriminate biopsy nor indiscriminate radiation before biopsy can be commended without reserve. Both should be safeguarded by sound clinical judgement and, not infrequently, the combined judgement of all concerned.

A biopsy should be done whenever the slightest suspicion of malignant disease exists.

It should be remembered that any indolent lesion, reluctant to heal, particularly when located in regions frequently subject to cancerous disease (cervix, mouth, lips, etc), and any "lump" in a breast, are all open to the suspicion that they may be malignant and if they are, the sooner this is known the better. It is not the suspicion of cancer which is to be feared but the careless optimism which denies or ignores the suspicion until it may be too late. As a general principle it may be said that the outlook for the successful treatment of cancer is best when the difficulties of diagnosis are greatest. Hence, the value of biopsy examinations. But it should also be emphasized that biopsy is only one of the phases of examination of the patient suspected of having a cancer and should not be relied upon to the neglect of a simultaneous thorough clinical study.

Valuable as a biopsy may be, it should never be decided upon without a careful consideration of all the factors involved and an appreciation of its limitations and possible dangers, and the final decision should always be governed by good clinical judgement and experience.

OTHER VALUES OF BIOPSY

Primarily, biopsy is a diagnostic procedure, but it also has other uses. For example, it may be used to determine the degree of malignancy as based upon the microscopic picture, and thus to form grounds for clinical prognosis or substantiate a prognosis already given. For, while the clinical picture may well justify a grave, if not hopeless prognosis, either the patient or his relatives may be reluctant—and naturally so—to accept it without microscopic proof.

Biopsy may also be used as a partial criterion of the sensitivity of a cancer to radiation and hence as a criterion of the possibility of the successful use of such therapy.

MICROSCOPIC DIAGNOSIS

The microscopic diagnosis of cancer must necessarily be based upon numerous factors of varying significance. Among these are: the character and appearance of the cells; the nature and degree of their variations from normal, their groupings and, particularly, their relation to the adjacent normal tissues.

One of the predominant features of a malignant growth is its ability to invade contiguous normal tissue. This, however, can be determined only when some of the adjacent normal tissue is included in the tissue examined. It is thus readily apparent that the information obtainable from the microscopic study of biopsy tissue is in definite proportion to the care and skill with which the specimen has been obtained.

For example: A suspicious lesion may appear as a crateriform ulcer, secondarily infected, with a control area of necrosis covered, perhaps, with a firm scab of dried exudate.

Obviously, the removal of the scab for microscopic examination will be useless, for little or nothing will be seen of the changes upon which the diagnosis of cancer depends.

It is equally clear that removal of necrotic tissue will also produce a tissue specimen of little or no value for microscopic study. In such case the biopsy specimen should be wedge-shaped and include the margin of the ulcer.

When there is clinical uncertainty whether or not a biopsy should be done, or from what portion of the lesion it should be taken, it is both wise and profitable to consult with the pathologist who will have to study the tissue.

ASPIRATION BIOPSY

Since 1930 when the technic of aspiration biopsy was first described by Martin and Ellis, it has attained widespread use in ever increas-

ing fields. It is indicated for tumors lying beneath the surface when it is desired to avoid an incision. Properly performed it has been a success. It avoids the objection of performing surgical biopsies through normal tissues. It is the most rapid of all biopsy procedures. The procedure, staining of the slide, and interpretations, can be done in fifteen minutes. Operations may frequently be avoided as in the case of breast cysts where simple aspiration usually suffices.*

HOW SHOULD A BIOPSY BE TAKEN?

Various methods are available for the removal of biopsy specimens. They may be excised with the scalpel cutting current of cautery or radioknife; "punched out" by various devices; secured by curettage; aspirated with needle and syringe; or, in the case of fluids, removed by needle and syringe or trocar.

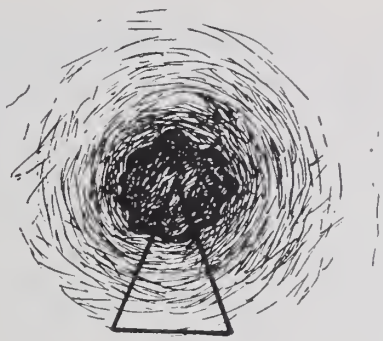
Which is the most suitable method depends upon the nature and location of the lesion, its predominant clinical manifestations and the clinical situation in general. The important thing is not how the specimen is secured but how suitable is it for microscopic study?

It is sometimes thought that biopsy excisions of tissue should always be done with the cautery or radioknife because lymph channels are thereby sealed off. It must be remembered, however, that the inevitable tissue coagulation which results, materially interferes with microscopic study and may render it inconclusive unless the excision has been relatively wide of the lesion.

THE PIE CUT TECHNIC

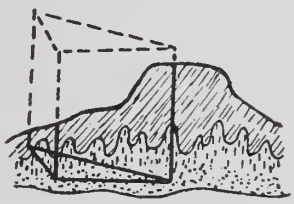
One of the most acceptable methods of biopsy is the pie cut technic, used in ulcerating lesion; this may be illustrated in the following steps:

1. Choose your site well, see figures 1 and 2.
2. Include some of the ulcer base edge and surrounding tissue.
3. Grasp edge lightly with forceps and raise up while undermining with knife. See figure 3.
4. When cautery is used employ cutting current and clean loop to insure minimum of charring.
5. A biopsy forceps is excellent for cervical lesions. This is an office procedure and is easily done.



(1)

Biopsy Technic



(2)

Biopsy Technic



(3).

Biopsy Technic

THE GOOD SPECIMEN

It is already obvious that size is not the sole (nor the best) criterion of a good biopsy specimen. Quality not quantity is the determining factor. The diagnosis of cancer may be clear-cut and final from a very small tissue fragment properly chosen, and doubtful or

* For the complete description of the aspiration biopsy, the reader is referred to the original article by Martin and Ellis. **Journal of Surgery, Gynecology and Obstetrics, 1930.**

inconclusive from a relatively large mass poorly selected. It cannot be too strongly emphasized that while a positive diagnosis of cancer from a small piece of tissue is final and absolute, a negative diagnosis from small tissue fragments is not necessarily as equally conclusive and should be corroborated by examination of a second biopsy.

When the lesion is small its total excision is preferable. This is often spoken of as a "therapeutic biopsy" because of the complete removal of the lesion.

By rapid frozen-section biopsy is meant the preparations of the tissue immediately after its removal so that it can be examined microscopically at once. The obvious advantage is that the interval between biopsy and operatiive removal of the tumor is reduced to minutes.

Rapid biopsy is advantageous when: (1) All proper technical facilities are at hand; (2) When the necessary skill in interpreting such specially stained sections is available.

However, it should not be considered the invariable method of choice to be resorted to under any and all circumstances. For this method has certain important and inherent disadvantages.

First and foremost is the fact that the tissue pathologist who must make the important decision, is forced to work under the definite demand for speed, speed, and more speed.

Five or ten minutes is a short time ordinarily, but to the surgeon, standing over an anesthetized patient with poised scalpel, it may seem an age. If the microscopic picture seen by the pathologist is definitely that of cancer, all is clear. But if, as it may be, it is indefinite and dubious and more sections are desirable, clear judgment and calm appraisal are difficult in the face of repeated and insistant demands for a report.

More than once has every tissue pathologist found nothing in the rapid sections upon which to base a diagnosis of cancer only to see such evidence clearly in subsequent paraffin sections prepared from the same block and studied carefully and without haste or turmoil.

Recently many pathologists have transected specimens removed in operating room for rapid study, and wiped some of the cells from the surface to form a thin smear which rapidly dries. This can be quickly stained as in the aspiration biopsy technic. Results are often better than with frozen sections.

With the development of the methods at present available, for the relatively rapid preparation of well cut and well stained paraffin sections, the importance of and necessity for rapid frozen section technic becomes less and less.

Whenever a rapid tissue technic is desired the pathologist should always be notified in ample time to make all necessary arrangements.

HOW SHOULD BIOPSY SPECIMENS BE SENT TO THE PATHOLOGIST?

Biopsy tissue should be placed in 10 per cent formalin (one part formalin to nine parts water) immediately upon removal and may remain in this fixative indefinitely.

The container furnished is large enough to allow the easy housing of the specimen.

Biopsy tissue should never be allowed to become dry and hardened; in the case of fluids or curetting, specimens should never be taken up on a swab, soaked up on cotton ,or enmeshed in gauze, from all of which the specimen can be removed only with difficulty, loss or damage.

WHAT INFORMATION SHOULD ACCOMPANY THE BIOPSY SPECIMEN?

It should be appreciated that the tissue pathologist is functioning essentially as a consultant and, as such, deserves the same courtesy afforded any other consultant. It is always well—and may sometimes be of the greatest value—for him to know the location of the lesion, its gross characteristics, its duration, predominant clinical characteristics and symptoms, the age and sex of the patient.

While the tissue itself may present a microscopic picture so clear-cut and definitive as to be conclusive *per se,* in the doubtful case the clinical data may assume great importance. It is important therefore that the card accompanying the biopsy specimen be completely filled in.

The classic axiom of Osler in reference to another disease may well be paraphrased:

Be quick to suspect cancer but slow to diagnose it and corroborate the diagnosis by all available means.

AMBULATORY ELECTRIC SHOCK TREATMENT *

Robert H. Stockfisch, M.D.,
Jersey City, N. J.

In selected cases, electric shock treatment may be administered in the practitioner's office. This has the advantage of obviating the feelings of shame or guilt which laymen so often attach to hospitalization in a mental institution. And it offers a less expensive means of treatment than placement in a private institution, and offers the head of a family a chance of returning to work sooner than would be the case if he were admitted to a mental hospital.

INDICATIONS AND CONTRA-INDICATIONS

Foremost consideration must be given to cases with obvious or inferred suicidal tendencies. The family must be acquainted with this danger and assume the responsibility of preventive measures until the first few treatments have been given. This is usually sufficient to reduce the suicide risk. The physical contra-indications are few. These should be anticipated by careful physical and neurologic examinations. During the past two years, it was only because of detailed neurologic examination that I was able to diagnose three cases of brain tumor which had been sent to me as psychoses. All were verified by operation.

TECHNIC

Treatments are usually given three times a week, in the morning. The patient has no breakfast or only a cup of coffee. Some member of the family (or a close friend) must accompany him to the office. After the convulsive state has passed and before consciousness returns, the friend or relative is asked to be present with the nurse, so that when the patient awakens in the usual state of confusion, he may recognize a familiar face or voice and thus neutralize the fear reaction which occurs in the first few treatments. The patient is allowed to rest for about an hour on the couch. An upholstered table with a minimum of metal is used. To prevent soiling by incontinence due to the force of convulsions, the patient is required to use the office lavatory. Artificial dentures are removed and the clothes loosened. I have used a team made up of another physician, one or two nurses and myself. A small pillow, supporting the lumbar area, helps prevent sudden hyperextension of the spine.

SEQUELAE

There are a few common but comparatively minor after-effects. These include mental confusion,[1] headaches or dizziness, all generally short and temporary in nature. At times, there are complaints of muscular pains due to the convulsive tonic and clonic phases. On occasion, there is a prolonged period of memory defects, in contrast to the usual 7 to 10 days [2] following the termination of treatment. Rarely we see a state of euphoria or hypomania, but this clears up in a short time. In my series, there was only one instance of proved fracture which involved the neck of the humerus in a 56 year old woman. The literature shows an occasional fatality—approximately 1 in 2,000.

PHYSIOLOGY

There is some question as to what changes take place in the brain as a result of electric shock therapy. According to one theory,[3] there are demonstrable gross and histopathologic changes in the brain—chiefly, hemorrhages. Other authorities [4] deny that the current produces any histopathologic changes in the central nervous system. Alexander and Lowenbach [5] in their experimental studies failed to find any vascular or parenchymatous changes. Kalinowsky [6] stated that he and Barrera had been unable to find any hemorrhages. Globus [7] et al. found no significant changes in carefully carried out experiments. Pacella and Barrera [8] noted changes in the electro-encephalogram during (and for a short period following) the termination of treatment. However, this picture did not persist.

* Read to the Journal Club of Neuropsychiatric Division of New York Post Graduate Hospital, January 24, 1947.

DURATION OF TREATMENT

The length of the treatment is based upon the individual reactions of the patient and the experience of the psychiatrist. As a rule, four to six treatments are sufficient in the reactive depressions, whereas twelve to twenty are necessary in the more severe types. The occurence of organic psychotic reactions, (as described by Kalinowsky[9]) may influence the course of the treatment with the inexperienced therapist. The recognition of these organic symdromes is of great importance. Treatment may be continued for an unnecessarily long time if these reactions are mistaken for an activation of the original psychosis. In other cases, interruption of therapy because of acute organic syndromes, brings about an incomplete recovery. If there is any doubt, a waiting period of seven to ten days is sufficient to exclude a temporary organic reaction.

PSYCHONEUROSIS

Results of the treatment of psychoneurosis by electric shock are displayed in table one. Patients number 13 and 17 were male; all others were female. It will be noted that in only one of the eighteen cases was the treatment a failure.

Case 2: This woman had always been a temperamental, highly imaginative person with previous compulsions to do things in two's or in multiples of two's. She had recently developed homicidal impulses towards her baby when she saw sharp or pointed tools. She entertained ideas of suicide. Following 16 electric shock treatments she became amenable to psychotherapy and regained insight.

Case 5: Ten days after delivery of her baby, this patient became "upset", weak and fatigued. Then she developed numerous fears. She thought her baby had died. For five nights, she kept herself awake for fear of nightmares. By then, she showed marked mental confusion and depression. During treatment, she became hypomanic but this cleared after 18 treatments. Full insight, permitting her to assume her regular duties, and take charge of her baby was affected after a short period of psychotherapy.

Case 17: Here was a 34-year-old male who was able to continue work receiving shock treatment in the evening. Ten years earlier he had had gonorrhea and this was followed by a severe guilt reaction and depression. He was committed to a State Hospital and made a good social recovery. There was a recurrence five years later. In the recent (third) attack, he had no desire to work and changed jobs frequently. There was insomnia and anorexia. He had thoughts of suicide. He acted out his guilt by becoming very religious, going to church many times a week. Under electric shock therapy, his mood changed considerably and with psychotherapy, there was a definite improvement in insight which has continued to date.

TABLE ONE: PSYCHONEUROSIS

Case No.	Diagnosis	Age	Prior Attacks	Duration of present episode	Number of Treatments	Results
1	AH	23	1	3 months	4	Improved
2	OC	24	0	5 weeks	16	Improved
3	RD	33	0	2 weeks	9	Remission
4	RD	28	0	6 months	8	Remission
5	RD	25	0	3 weeks	18	Remission
6	RD	24	0	6 weeks	10	Remission
7	RD	31	0	4 weeks	8	Remission
8	RD	37	3	3 months	12	Remission
9	RD	33	1	2 months	12	Remission
10	RD	62	0	1 year	4	Improved
11	RD	45	0	5 months	12	Improved
12	RD	28	0	4 months	11	Improved
13	AD	35	0	2 years	6	Remission
14	AD	27	0	5 months	6	Improved
15	AD	31	2	5 weeks	5	Improved
16	RD	38	2	4 weeks	4	Improved
17	RD	34	2	3 months	6	Improved
18	HD	54	0	5 years	4	Failure

Notes to table: Patients Number 13 and 17 were male; all others were female. Diagnostic abbreviations as folows: AD—Anxiety with depression; AH—Anxiety, hysteria; HD—Hysteria with depression; RD—Reactive depression; OC—Obsessive-compulsive.

Note that the patients with reactive depression did well, and with one exception, needed comparatively few treatments. Several of these cases are worth especial comment.

MANIC DEPRESSIVE PSYCHOSES

Nine patients with manic depressive psychoses were treated by electric shock. There was one failure. Five improved and three enjoyed a complete remission. See table two.

TABLE TWO

MANIC-DEPRESSIVE PSYCHOSIS

Case Number	Type	Sex	Age	Prior Attacks	Present Episode (months)	Number of Treatments	Results
1	D	M	38	0	12	12	Complete remissions
2	D	F	60	2	2	8	Improved
3	D	M	37	0	12	9	Complete remission
4	D	M	64	2	1	6	Improved
5	D	F	19	4	3	12	Failure
6	D	F	30	1	3	6	Improved
7	Mc	F	38	0	1	10	Complete remission
8	Mc	M	40	0	4	12	Improved
9	Mc	F	25	1	1	12	Improved

Note: Type is indicated as depressed (D) or manic (Mc).

Case 7 is typical of this group. This was a 38 year old woman who had apparently "psychoneurotic" symptoms for some time prior to the manic episode. She complained of headaches, weak spells, choking sensation, lack of ambition and insomnia. In January 1944, she developed an acute manic attack and became disoriented, restless and incoherent. She tried to run out on the street without clothes. Ten shocks plus psychotherapy resulted in a complete remission, improved insight and social adjustment.

INVOLUTION MELANCHOLIA

Seventeen cases of involution melancholia are presented in table three. In one case there was failure, and in two there were relapses after remission. The unfavorable results appear to have been associated with schizoid trends.

Typical of this group is case 3, a man of 52 who complained of "butterflies in the stomach", depression, insomnia, loss of appetite and weight, loss of libido and fatigability. He thought that other people were better than he. With eight shock treatments, followed by neohombreol (by mouth) and subsequent psychotherapy, he made a complete recovery.

We were less fortunate in Case 5. This was a 43-year-old woman who gave a history of four months duration of headaches, hot flashes and dizziness, followed by restlessness and irritability. This was followed by periods of depression. Then she felt that she was going blind and becoming insane. She lost interest in her family and housework. At the end of 18 treatments, she was only in partial remission. She did not react to psychotherapy and became more depressed, making an attempt at suicide. It was necessary to commit her to the state institution.

TABLE THREE

INVOLUTION MELANCHOLIA

Case Number	Age	Previous Reactions	Present Episode in months	Number of Treatments	Results
1	54	2	2	12	Complete remission
2	60	0	6	6	Complete remission
3	52	0	3	8	Complete remission
4	46	2	2	12	Complete remission
5	43	0	4	12+6	Remission; then relapse
6	48	0	1	12	Complete remission
7	51	2	3	12+6	Remission; then relapse
8	54	0	6	12	Failure
9	62	1	3	10+5	Improved
10	53	0	24	12	Complete remission
11	50	0	24	12	Complete remission
12	48	0	3	12	Complete remission
13	40	0	4	12	Complete remission
14	55	0	3	11	Complete remission
15	53	2	12	13	Complete remission
16	58	0	10	12	Complete remission
17	58	0	12	12	Improved

NOTES. Patients number 3, 9 and 17 were males. All others were female. In cases number 5, 7 and 9, treatment was administered in two series, as indicated in the column.

SCHIZOPHRENIA

Results were less impressive in schizophrenia than in any other diagnostic category. Twenty one patients were treated with nine failures. Results are displayed in table four.

TABLE FOUR
SCHIZOPHRENIA

Case Number	Type	Age	Sex	Present Episode	Number of Treatments	Results
1	P	30	F	5 months	19	Failure
2	C	45	F	1 month	17	Remission
3	C	27	F	9 months	28	Failure
4	S	41	F	4 months	12	Remission
5	P	54	F	1 year	12	Failure
6	C	29	F	1 year	12	Improved
7	C	58	M	18 months	9	Remission
8	S	15	F	2 years	12	Remission
9	P	28	F	4 months	11	Remissions
10	C	61	F	6 months	12	Failure
11	P	66	F	1 year	12	Failure
12	C	40	F	1 year	12	Failure
13	P	24	F	4 months	11	Improved
14	P	52	F	3 months	11	Failure
15	P	34	F	5 years	12	Improved
16	P	50	F	5 years	16	Failure
17	P	57	F	2 weeks	12	Remission
18	S	24	F	4 weeks	9	Remission
19	H	35	F	6 weeks	12	Remission
20	S	21	M	2 years	6	Remission
21	H	17	F	2 months	12	Remission

Notes Results marked "remission" indicate complete remission. Patients 2 and 3 had had prior hospitalization for psychosis. In the "type" column, the letters C, H. P. and S indicate catatonic, hebephrenic, paranoid and simple forms respectively.

In this category, the following cases are illustrative:

Case 2—A history of commitment twelve years ago with spontaneous remission. This recurred two years ago with symptoms of personality changes. She became morose and moody, sitting many hours by herself. She was negativistic in other respects. She felt she was being punished for her masturbation. This cleared up after five shock treatments but after two years there was a recurrence. This time it took 17 treatments and psychotherapy to bring about a complete remission, which has now endured for more than two years.

Case 17—Illustrates success in an acute schizophrenic episode. She was always a "nervous type," a self-centered person who liked sympathy. She developed an acute episode in which she became critical of her neighbors and expressed ideas of reference. She also had auditory hallucinations and a persecutory delusion. She made a complete recovery with shock therapy and follow-up psychotherapy.

Case 19—This woman had had a "nervous breakdown" 13 years ago ascribed to worry over her job. She recovered in six months. During that time, she prayed excessively and had visual hallucinations—seeing nuns wherever she looked. Six years ago, she had a slight relapse. The present episode started 6 weeks previously during her vacation. She became very nervous and had the same visual hallucinations. Then she became depressed and expressed suicidal thoughts. After 8 treatments, she became greatly improved and with psychotherapy developed a better insight, so that she was able to return to work.

RESUME OF RESULTS

In table five, only cases which were followed for at least one year after termination of electric shock treatment are considered. Results are evaluated according to the following factors: relief of symptoms, social recovery (permitting return to work) and improvement of insight. Although in some cases, results are almost miraculous, there is no real improvement in insight unless proper phychotherapy is instituted. This is borne out by a number of cases in which the family insisted there was a "cure" and refused the usual follow-up psychotherapy. Result was a relapse. I have deviated from the usual technic in

TABLE FIVE

RESUME OF RESULTS

Classification	No.	Complete Remission	Improved	Failure	Average No. of Treatments	Per Cent of Failure
Psychoneurosis	18	9	8	1	8.6	5.5%
Manic-depressive	9	3	5	1	9.6	11.1%
Involution melancholia	17	12	2	3	12.5	17.6%
Schizophrenia	21	9	3	9	12.6	42.8%
Total	65	33	18	14	10.8	21.5%

the acute manic states. Here I have noticed that several superimposed convulsions on the first few occasions brought about a more rapid subsidence to a tractable state.

As Quintilian says: "In almost everything, experience is more valuable than precept." There is much work to be done before we understand the basis of shock therapy and before we can scientifically compare results with other modes of treatment. It is true that the patient undergoing electric shock is thrown into a state that is contrary to normal physiologic functioning. But in practice, results are encouraging enough to justify use as a purely empirical approach until a better understood and more effective method is found.

3637 Boulevard

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NEW TUBERCULOSIS EXECUTIVE

William A. Doppler, industrial relations director of the National Tuberculosis Association has been named to succeed Ernest D. Easton as executive secretary of the New Jersey Tuberculosis League and will assume the duties of his new position April 1.

Mr. Doppler has been in the service of the National Tuberculosis Association since 1935, first as a staff worker for health education and then as director of the annual diagnosis campaign. He is the author of pamphlets and publications on tuberculosis which have had a circulation of more than 25 million copies.

Mr. Doppler received his doctorate from the University of Zurich, Switzerland, in 1914, majoring in bio-chemistry. He did graduate work at the Pasteur Institute in Paris, served as a bacteriologist in the First World War and worked with Herbert Hoover in postwar rehabilitation of Central Europe.

TOP CIVIL SERVICE POSITIONS NOW AVAILABLE

Applications are now being accepted by the U. S. Civil Service Commission, Washington 25, D. C., for physicians who have specialized in maternal welfare, child health, pharmacology, epidemiology, pathology, bacteriology or public health. No written examination is required, each candidate being rated on the basis of experience and training. The salary range is from $7100 to $10,000 a year. Former medical officers of the army or navy enjoy a five-point bonus in the rating of their qualifications, and veterans with service-connected disabilities are entitled to a ten-point bonus. For application blanks and further details, write to the U. S. Civil Service Commission at the Federal Building, Christopher Street, New York 14, N. Y., or to the U. S. Civil Service Commission, Custom House, 200 Chestnut Street, Philadelphia 6, Pa. Ask for Circular EC-5 and Application Forms 14 and 57.

SCLERODERMA TREATED WITH PROMIN*

WITH REPORT OF A CASE

VIRGINIA WUERTHELE, M.D., Newark, N. J.

Purpose of this report is to record the dramatic effect of a new drug on a well-established case of scleroderma. Scleroderma is a disorder of unproved etiology, involving chiefly the skin but also, secondarily, the subcutaneous tissues, blood vessels, and nerve supply to the parts affected. It is characterized by doughy swellings in the skin which gradually merge into the hard wooden indurations which give the disease its name: scleroderma. The skin becomes hard and tight; the mucous membranes may also be involved; nodules often appear in circumscribed areas. A common type, called *sclerodactylia,* is the result of scleroderma of the hands in which the skin of the fingers, as well as the subcutaneous tissues, undergoes marked atrophy, so that the hands become clawed. Swelling of the fingers frequently occurs with ulcerations under the nails and severe pain. The hands may become useless appendages, affording nothing but constant pain to the sufferer. It is such a case that was treated with a sodium diaminodiphenyl sulfone, packaged by Parke-Davis under the trade-marked name of *promin.*

RATIONALE

Although the cause of scleroderma is unknown, the remarkable resemblance of scleroderma to certain lesions of leprosy has been noted by many writers. While there are many differences, the similarities are even more striking. In addition, previous to the use of promin, chaulmoogra oil was used extensively for the alleviation of the signs and symptoms of leprosy. And until now, the only medication of any value in scleroderma has been dihydrotachysterol packaged by Winthrop under the trade-name of *hytakerol.* The similarity in chemical structure of the two products is evident. Chaulmoogra oil and hytakerol as therapeusis are comparable. On release of the material on promin, it seemed that since it was effective in the treatment of leprosy, it might be helpful in the treatment of scleroderma. It is not suggested that these two diseases are of the same etiology, but the similarity in the type of therapeutic oil-soluble vitamin preparation used in both diseases, suggested the use of promin.

The case here reported is that of a white woman, aged 52, a nurse, intelligent and cooperative. In 1938, she first noticed splinter-like lines, very tender, under the nails. The index fingers of both hands were dry, numb, scaling, and tingling. In 1939, the second finger of the right hand became swollen and extremely painful. A diagnosis of cellulitis was made in 1940. The fingers at this time became cold and white. A lump developed on the ulnar surface of the left arm in 1942. Numbness, pain and ulcerations of the second and third fingers of both hands occurred. At this time a complete physical study revealed no unusual findings except a basal metabolic rate of minus 6 per cent, generalized infection of the mouth, and overweight of twenty-five pounds. All these conditions were corrected. The patient was then advised to consult Dr. William Bierman of Mt. Sinai Hospital, New York, for physiotherapy as a means of relief of pain. He confirmed the diagnosis of scleroderma and suggested the use of hytakerol. The patient received this drug with fair regularity from March 1942 until July 1946. There was some alleviation of the symptoms but no true regression of the disease. Calcium-phosphorus ratios were studied periodically and the dosage adjusted to the blood levels. In October 1945, the patient was admitted to the St. Barnabas Hospital in Newark, N. J. The only general finding here was early hypertrophic osteoarthritis of the knees and dorsal-lumbar areas.

In September 1946, she reported extreme pain, great swelling and marked clawing of the hands. Examination of the hands at this time showed club-like, purple fingers, markedly contracted and painful. The patient felt hopeless and begged for an amputation of the left

* Read before New York Academy of Medicine, February 4, 1947.

index finger. Ulcers were found under the nails of the second and third fingers of both hands and on the medial side of the right index finger. The nails were clawed and adherent to the underlying ulcers. The tip of the fourth finger of the left hand was beginning to break down in addition to swelling and pain. Codeine was needed at frequent intervals for relief. The patient had to wear padded gloves at all times. Even air currents caused pain. The hands were entirely useless. She could not dress herself or care for her home. She could not open a door by the knob, hold a cup, make a bed or use her hands for any small coordinated tasks. The slightest touch caused acute pain. At this stage on November 14, 1946, promin jelly (a 5 per cent promin in tragacanth), was applied liberally to the hands three times daily and covered with white gloves. Improvement in pain was noticed after two days. The ulcers stopped oozing and began to dry after one week. No further codeine was needed. The patient could touch her fingers to objects without pain. On December 7, 1946, the ulcer on the medial side of the right index finger began to heal over with a firm, dry crust. The subungual ulcers healed entirely. On December 17, 1946, the hands presented a marked improvement. The fingers were almost entirely straightened out, the swelling had subsided. The patient was able to dress and feed herself, to sew, make beds, open doors. Even knocking the fingers against a table caused no pain. She was ready to return to work by January 1947. No other therapy was used and this treatment will be continued. Promizole tablets will be administered as a followup after the ulcerations have completely disappeared.

Intensive work must be done to determine whether promin is an antibacterial agent and to discover the etiologic agent in scleroderma. We must learn too, whether the similarity between leprosy and scleroderma is significant. And the possibilities of promin must also be investigated in the treatment of other skin lesions.

NOTE: *Promin is sodium P, P¹—diamino-diphenyl sulfone —N, N¹—di—(dextrose sulfonate).*

560 Mt. Prospect Avenue

ONLY TWO PER CENT TINCTURE OF IODINE NOW OFFICIAL

When the new U.S.P. XIII becomes official in April of this year, the old familiar seven per cent tincture of iodine will be obsolete. In the last Pharmacopoeia three iodine antiseptics were recognized. There was the *mild tincture of iodine* which was a two per cent preparation, and there was the seven per cent *tincture of iodine,* and finally, a two per cent *aqueous solution.* The latter has been discarded because it freezes too easily in cold weather. The seven per cent tincture of iodine is also being dropped as an official preparation because it sometimes retards healing due to tissue destruction.

Effective in April, therefore, a prescription for tincture of iodine will call for the two per cent preparation. This is just as efficient as an antiseptic and germicide as is the old seven per cent tincture and it is far less irritating when applied to open wounds. It will not smart or sting as did the old seven per cent tincture.

Physicians who for any reason still want the seven per cent tincture, may obtain it by calling for *strong iodine tincture National Formulary VIII.*

Iodine is absorbed by the sulfur in the ordinary rubber stopper used in bottles, and the new synthetic butyl rubber stopper is recommended as far superior in iodine absorption resistance to natural rubber or to the ordinary buna rubber.

ACUTE OSTEOMYELITIS OF THE CERVICAL SPINE WITH PROBABLE EPIDURAL INFECTION*

REPORT OF CURE WITH PENICILLIN THERAPY

By LAWRENCE I. KAPLAN, M.D., New York, N. Y., and
HILTON S. READ, M.D., Ventnor, N. J.

Osteomyelitis of the cervical spine is relatively rare. Harbin and Epton,[1] in a short review of the disease, presented one case of involvement of the sixth cervical vertebra, associated with normal spinal fluid findings. Turner[2] reported twelve cases of acute infectious osteomyelitis of the spine, two of which involved the cervical region, ending fatally. Kulowski[3] described a case of osteomyelitis of the second and third cervical vertebrae presenting the clinical picture of a retro-pharyngeal abscess. In Wilensky's[4] analysis, twelve instances of cervical spine involvement were found in a series of 578 cases of osteomyelitis at the Mt. Sinai Hospital in New York City.

Infection of the epidural space secondary to osteomyelitis of adjacent vertebrae was described by Browder and Meyers,[5,6] with detailed pathologic evidence. Three of their fourteen cases involved the cervical region. Recently, Scoville and Raskind[7] reported a case of acute pyogenic osteomyelitis of the body of the fifth cervical vertebra with destruction, spinal collapse and cord compression. Diagnosis was difficult early in their case because of normal x-ray findings and lack of clinical localization. Recovery resulted following surgical drainage.

It seemed of interest, therefore, to present a case of acute infectious osteomyelitis of the sixth cervical vertebra with probable involvement of the spinal epidural space, evidenced by abnormal spinal fluid findings. The diagnosis was based on the clinical history and findings, in the absence of demonstrable bony changes. It was confirmed by impressive roentgenographic evidence of extensive vertebral destruction.

CASE REPORT

A 26-year-old white private was admitted to his station hospital on 15 February 1944, complaining of a painful neck. For one week prior to admission, he experienced increasing pain and stiffness of the neck, with sensations of chilliness, general malaise, headache, and loss of appetite. He had had several furuncles on his back a few weeks previously, but disregarded them. Following admission to the station hospital, he ran a temperature of 103 degrees F., and a blood culture taken on 23 February, was found to be positive for hemolytic staphylococcus aureus. X-rays of the cervical spine at that time were negative. Because of the blood stream infection, he was started on sulfadiazine, and temperature dropped to normal in two to three days, following which, subsequent blood cultures were repeatedly negative. Sulfadiazine was discontinued on 6 March.

One week following his discharge from the station hospital, he developed low-grade fever, which continued until his admission to this general hospital on 23 March. He complained of pain centered chiefly around the upper medial border of the left scapula.

Neurologic examination revealed minimal weakness and suggestive atrophy of the supraspinatus and infraspinatus muscles bilaterally. There was tenderness on deep pressure over the lower cervical spinous processes, and marked limitation of forward flexion of the cervical spine. Rotary and extension movements in this region, however, were performed with little difficulty. There was no impairment of reflexes and no sensory changes, although the patient occasionally complained of radiation of pain from the neck to both shoulder regions. Physical examination, otherwise, was essentially negative.

While hospitalized, the patient had a daily rise of temperature to 102 degrees F. in the late afternoon and early evening. X-rays of the cervical spine the day following admission, and review of the original films, revealed a normal appearance with no change. Roentgenographic examination of the chest was likewise negative. White blood count ranged between 15,000 and 18,000, with a preponderance of polymorphonuclear leukocytes. Sedimentation rate was elevated to 59 millimeters per hour.

Spinal fluid examination on 30 March, revealed a clear fluid under an initial pressure of 90 millimeters of water, with no evidence of subarachnoid block on manometric studies. Cell count, Wassermann reaction, colloidal gold curve, spinal fluid smear and culture were all negative. However, the total protein in the spinal fluid was *increased* to 120.5 milligrams per cent. It was then felt, in all likelihood, that the elevated protein reflected irritative meningeal changes from probable epidural involvement in the cervical region secondary to a metastatic osteomyelitis of the cervical vertebrae, not yet evi-

* From the Medical and Surgical Services, Finney General Hospital, Thomasville, Georgia.

dent on x-ray examination.† This impression was confirmed by x-ray examination on 10 April, which revealed extensive destruction of the sixth cervical vertebral body with considerable anterior wedging, producing a localized kyphosis. The contours of the fifth and seventh cervical vertebral bodies were not appreciably altered, and the adjacent intervertebral discs were apparently intact, although they were not too clearly defined. There was increased soft tissue density posterior to the hypopharynx.

Although spinal fluid culture was negative, and organism-sensitivity to penicillin could not be determined, the history of the recent staphylococcus aureus bacteremia, plus the clinical and x-ray findings, justified intensive penicillin therapy. On 11 April, the patient was placed in traction with a trial head halter. Continued traction was maintained by the attachment of 7 pounds of weight to the halter. He received 25,000 units of pencillin intramuscularly every 3 hours day and night, from 11 April, to 19 May, for a sum total of 7,600,000 units of penicillin. At this time, he was removed from the halter and placed in a body cast which supported his head and neck. From then on, convalescence was uneventful. Temperature remained normal, and he experienced only occasional minimal pain in the cervical region on extreme extension of the neck. On 1 January 1945, immediately prior to discharge from the hospital, x-ray examination of the cervical spine showed almost complete healing, without fusion of the vertebral bodies.

In the early stages of this case, the normal x-ray studies, associated with probable involvement of the epidural space, were findings similar to those described by Browder and Meyers.[5, 6] They demonstrated that failure to identify abnormal x-ray changes should not rule out spinal epidural infections, the majority of which are secondary to osteomyelitis of adjacent vertebrae, if the other signs point in that direction. These authors stated that it was rare to find roentgenographic evidence of spinal column changes, even in the presence of a well-established osteomyelitis.

The infrequency of osteomyelitis of the cervical spine has been attributed by Wagoner[8] to the preponderance of reticulo-endothelial elements in the sinusoidal spaces of the vertebral bodies and to the high phagocytic power of this material, or cells. The bodies of the vertebrae are always the site of infection when it occurs in the cervical spine. According to Pancoast et al,[9] no cases, involving the pedicles, laminae, or spinous processes, have been observed. The preservation of the intervertebral discs, in spite of the fact that considerable destruction of vertebral bodies may exist, is explained by the lack of weight-bearing in this portion of the spine.

Recovery from acute osteomyelitis of the cervical spine, following penicillin therapy without surgical intervention, is added as record to the literature.

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5407 Atlantic Avenue

HELLO TO THE GRAM

The editorial *Goodbye to the Grain,* published on page 485 of the December JOURNAL has called forth comment from E. Fullerton Cook, Chairman of the Committee on Revision of the Pharmacopoeia of the United States. Mr. Cook makes the following remarks:

"I appreciate your feeling about losing an old friend, but I am convinced that those who have grown up with the 'grain' and are really willing to try to learn and use the metric system will soon find it a great advantage.

"Those who think metrically will prescribe 5 cc. (not 4 cc.) for the condition calling for 'about a teaspoonful dose', and then their calculations for the 100-cc. prescription will be easy and they will see that they have twenty doses or enough medicine, three times a day, for a week (less one dose).

"When one thinks of 4 cc. as the dose, one is being influenced by the old system and the thought of a drachm and a teaspoonful as being the same. We should forget the drachm. As a matter of fact, the modern teaspoon, available in a home, is much more likely to be 5 cc. than 4 cc.

"I hope that you will help establish the metric dose and not discourage it. At best it will take years to make it universal. I believe it was Osler who said that most men after 40 won't learn."

† The diagnosis was first made by Capt. Joseph Hahn, M.C., Chief of Neurology Section.

THE HOSPITAL SURVEY AND CONSTRUCTION ACT

By HENRY A. COTTON, JR., M.D., Trenton, N. J.
Deputy Commissioner for Mental Hygiene and Hospitals,
Department of Institutions and Agencies

On August 13, 1946, the President signed the Hospital Survey and Construction Act (Public Law 725—79th Congress). Purpose of this Act is to authorize grants to the states for surveying their hospitals and public health centers and for planning construction of additional facilities, and to authorize grants to assist in such construction.

There is an initial authorization of $3,000,000 to assist the states in carrying out the surveys and an annual appropriation of $75,000,000 for five years or a total of $375,000,000 for assisting the states in actual construction of hospitals and health centers. New Jersey's share is to be $93,928 for the survey, and $1,313,775 annually for five years for construction.

The law provides that before funds in either category can be granted each state must:

1. Designate a single state agency as the sole agency for administering the act.
2. Provide for the designation of a State Advisory Council.
3. Provide for an inventory of existing hospitals and a survey of the need for construction of additional hospitals, and
4. Make reports in such form and containing such information as the Surgeon General may require, and give the Surgeon General access to the records on which such reports are based.

The Governor has designated the Department of Institutions and Agencies to make the necessary inventory and survey, and to administer the funds for New Jersey. A State Advisory Council consisting of twenty-five persons from representative groups throughout the State has been designated.

GENERAL REGULATIONS

The law provides that within six months the Sugeon General of the U. S. Public Health Service will, with the approval of the Federal Hospital Council and the administrator, prescribe by general regulation:

1. The number of general hospital beds required to provide adequate hospital services and the general methods by which such beds will be distributed among base areas, intermediate areas, and rural areas. The total of such beds for any state must not exceed 4½ per thousand population.

2. The number of beds required to provide adequate hospital services for tuberculous, mental and chronic disease patients and the general methods by which such beds will be distributed. The total number of beds for tuberculous patients must not exceed 2½ times the average annual deaths from tuberculosis in the state over the period from 1940 to 1944. The total number of beds for mental patients shall not exceed 5 per thousand population, and the total number of beds for chronic disease patients shall not exceed 2 per thousand population.

3. The number of public health centers and the general method of distribution of such centers throughout the state. Such centers shall not exceed 1 per 30,000 population.

4. The general manner in which the state agency shall determine the priority of projects based on the relative need of different sections of the population and of different areas lacking adequate hospital facilities, giving special consideration to hospitals serving rural communities and areas of relatively small financial resources.

5. The general standards of construction and equipment for hospitals of different classes and in different types of location.

6. That the state plan shall provide for adequate hospital facilities without discrimination on account of race, creed, or color, and shall provide for adequate hospital facilities for persons unable to pay. Such regulation may require that (before approval of any application for a hospital or addition to a hospital is recommended by a state agency) assurance shall be received by the state from the applicant that:

a. such hospital or addition to a hospital will be made available to all persons residing in the

territorial area of the applicant, without discrimination on account of race, creed or color, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group; and

b. there will be made available in each such hospital or addition to a hospital a reasonable volume of hospital services to persons unable to pay but an exception shall be made if such a requirement is not feasible from a financial standpoint.

7. General methods of administration of the plan by the designated state agency.

REQUIREMENTS FOR STATE PLANS

After the above regulations have been issued, any state desiring to take advantage of the act may submit a state plan which will:

1. Designate the single state agency referred to above.

2. Contain satisfactory evidence that the state agency designated will have authority to carry out such plan.

3. Provide for the designation of a State Advisory Council.

4. Set forth a hospital construction program:

a. which is based on a state-wide inventory of existing hospitals and survey of needs,

b. which conforms wth the regulations prescribed by the Surgeon General,

c. which in the case of a state which has developed a program under provisions of this Act, conforms to the program so developed except for any modification required in order to comply with regulations prescribed and except for any modification recommended by the designated state agency, and

d. which meets the requirements as to lack of discrimination on account of race, creed, or color and for furnishing needed hospital services to persons unable to pay therefor.

5. Set forth the relative need determined in accordance with the regulations prescribed for the projects included, and provide for the construction insofar as financial resources available therefor for maintenance and operation make possible, in order of such relative need.

6. Provide methods of administration of the state plan.

7. Provide minimum standards for the maintenance and operation of hospitals which receive federal aid.

8. Provide for affording to every applicant for a construction project an opportunity for hearing before the state agency.

9. Provide that the state agency will make such reports as the Surgeon General may from time to time reasonably require, and give the Surgeon General, upon demand, access to the records upon which such information is based.

10. Provide that the state agency will from time to time review its hospital construction program and submit to the Surgeon General any modifications thereof which it considers necessary.

HOW TO APPLY FOR FUNDS

Any public or non-profit hospitals desiring to receive funds under this Act should submit an application setting forth:

1. Description of the site for the project.
2. Plans and specifications in accordance with regulations prescribed above.
3. Reasonable assurance that title is, or will be, vested solely in the applicant.
4. Reasonable assurance that adequate financial support will be available for the construction, maintenance and operation of the project.
5. Reasonable assurance that the rates of pay for laborers and mechanics engaged in construction of the project will be not less than the prevailing local wage rates for similar work as determined in accordance with Public Law 403 of the 74th Congress.

In connection with the non-profit hospitals attention is called to Article I, Clause 20 of the New Jersey State Constitution, which reads as follows: "No donation of land or appropriation of money shall be made by the state or any municipal corporation to or for the use of any society, association or corporation whatever."

The Department of Institutions and Agencies will accordingly submit the New Jersey plan to the Surgeon General for approval.

After the plan has been approved, the Federal Government will contribute 1/3 of the cost of the approved projects. The other 2/3 will be borne by the local hospital or agency sponsoring it.

No applications will be disapproved until the Surgeon General has afforded the State agency an opportunity for a hearing. However, since the total amount available for New Jersey for

a five year period is only $6,568,875, it is obvious that it will be impossible to meet the needs of the state and also satisfy all applicants. It is the intention of the Department of Institutions and Agencies to screen each application carefully and impartially according to its individual merits and according to the priorities to be set up by the Surgeon General.

A number of applications have already been received, but no funds will be available until after the survey has been made and the plan approved by the Surgeon General. This survey is to be conducted under the direction of Dr. Emil Frankel of the Department of Institutions and Agencies and will probably not be finished before July 1, 1947.

Applications listing the information outlined above may be submitted to the Department of Institutions and Agencies at any time. All applications, questions, and correspondence relative to this Act should be addressed to Sanford Bates, Commissioner, Department of Institutions and Agencies, State Office Building, Trenton 7, New Jersey.

135 West Hanover Street

TWENTY-FIVE NEW FELLOWS IN A. C. S.

The American College of Surgeons announces that the following New Jersey practitioners were received into Fellowship at the Convocation of the A.C.S. held on December 20, 1946:

John E. Annitto	Jersey City
Edward N. Bookrajian	North Bergen
Francis B. Brogan	Paterson
Alton E. Bythewood	Newark
Gerald I. Cetrulo	Newark
C. Chester Chianese	Trenton
Rosario J. Cottone	Trenton
Louis Davis	Newark
Daniel B. Eck	East Orange
Lester R. Eddy	Sussex
John J. Flanagan	Newark
Euclid P. Ghee	Jersey City
William F. Grant	Newark
Daniel G. Jarvis	Newark
Clement M. Jones	Bayonne
J. Harold MacArt	South Orange
Albertos M. K. Maldeis	Camden
Anthony G. Merendino	Atlantic City
James A. Moore	Montclair
Francis W. Pizzi	Orange
Arthur Sack-Wilner	Trenton
Emil L. Santangelo	Paterson
Edwin A. Seidman	Newark
Glen L. Yates	Glen Ridge

USPHS NEEDS NURSES

Examination for appointment of nurses to the United States Public Health Service will be given at 67 Hudson street, New York City, on February 25 and 26. The salary scale ranges from $2955 to $3915 annually. For further details write to Chief, Division of Nursing, United States Public Health Service, Washington 25, D. C.

NEW ACADEMY LIBRARIAN

The Academy of Medicine of Northern New Jersey announces the appointment of Mr. Harold M. Goettel as librarian in charge of the extensive collection of medical books and periodicals housed at 91 Lincoln Park, Newark. Mr. Goettel received his B.A. degree from the University of Pennsylvania and subsequently was awarded a B.S. in library science by the University of California. He did postgraduate work in library science at Columbia University and was brought to the Newark Free Public Library at the end of 1944. He became senior lending and reference librarian with assignment to the Academy on October 1, 1946; and as a result of civil service, his appointment was made permanent on January 20, 1947.

MEMO TO CORNELL ALUMNI

Alumni Day for Cornell University Medical College will be held on Thursday, March 13. at the Alumni Room in the college building at 1300 York avenue in New York City. Luncheon will be available in the Nurses' Home and business meetings, rounds and scientific conferences are scheduled for the afternoon. The program comes to a climax with a dinner at the Hotel Roosevelt that evening. For more details write to Alumni Association, room F-110. at the Cornell University Medical College, 1300 York avenue, New York 21, N. Y.

ERROR ON CIBA SLIDE RULE

Because of a manufacturer's error in the placement of a decimal point, the conversion from 0.4 grain in the Ciba slide rule is incorrect. It should read 0.025 Gram and not 0.25. Physicians using the slide rule should paste a little tab over the erroneous figure. The Ciba Pharmaceutical Company expects to distribute a new celluloid table as soon as possible.

TRUSTEES' MEETING

JANUARY 26, 1947

A regular meeting of the Board of Trustees was called to order at 1 p. m. on January 26, 1947. Present were Doctors Crowe, Green, Schaaf, Norton, Dodd, Costello, Johnsen, Lance, Hornberger, Alexander, Scammell, Fithian and Sica. Dr. Young, Dr. Lee and Dr. Stahl were excused. Also present, on invitation were Doctors Barkhorn, Scott, Davidson and Lewis. Dr. Crowe, Chairman of the Board, presided. An abstract of the proceedings follows.

The Board elected Dr. Francis C. Weber of Newark as Judicial Councilor for the first district. Dr. Weber, filling the unexpired term of the late Dr. Beling, will serve until the 1947 Annual Meeting.

Dr. Schaaf, chairman of the committee to select an Executive Officer, reported that they had canvassed the country and that they were now prepared to recommend a suitable candidate for the post. The Board appointed a special committee to interview the applicant, with authority to make the appointment on a one-year basis. The special committee consists of Doctors Fithian, Costello, Lance, Scammell and Johnsen.

Dr. Schaaf reported on conferences held with reference to the proposed cancer clinic at a hospital in Essex County. The Board was also informed that the pathologists in this state have now been organized so that they are able to provide a prompt biopsy service which will be financed by the New Jersey division of the American Cancer Society; and that plans for a central tumor registry are now being formulated.

Dr. Alexander reported on a meeting in Washington with Senators Taft, Ball and Smith, for the purpose of discussing the proposed National Health Act.*

Dr. Scott presented three reports. One covered the termination of the Farm Security plan, one reviewed the Survey of Rural Medical Services, and one tabulated the experiences of the Medical Service Administration and the Medical-Surgical Plan for the calendar year 1946. Copies are on file at the Executive Office.

MEDICAL PRACTICE AND LEGISLATION

The recommendations of Sub-committee on Legislation (page 67, this JOURNAL) transmitted through the Welfare Committee, were approved by the Board. The recommendations of the Sub-committee on Medical Practice (page 73, this JOURNAL) were also approved. On the problem of auxiliary medical services, the following resolution, prepared by Dr. Johnsen, was adopted by the Board of Trustees:

> Resolved that the Board of Trustees of The Medical Society of New Jersey call to the attention of the N. J. Hospital Association the fact that anesthesiology, physical medicine, radiology and clinical pathology are all branches of the practice of medicine, and that exploitation of these medical services by hospitals and by hospital plans, violates the principles of ethics of the American Association.
>
> And it is further resolved that a copy of this resolution be forwarded to each hospital in New Jersey,
>
> And that the Welfare Committee is hereby requested to investigate and report to this Board the nature and extent of violations of these principles,
>
> And that each hospital be considered responsible for the conduct of these services,
>
> And that the cooperation of the county medical societies be considered essential if changes in these practices are to be accomplished.
>
> Therefore, the Board of Trustees recommends that before any further action be taken, more definite information be made available.

The Board of Trustees approved the Welfare Committee's request that the Society assume the expense of printing and distributing the fifth edition of the *New Jersey Formulary*.

PUBLIC RELATIONS

The recommendations of the Sub-committee on Public Relations were next considered. The Board approved the continuation of the *Health Hints* weekly column. The Welfare Committee's recommendation that this Society protest to the A.M.A. their refusal to consider New Jersey's nomination for the centennial broadcast was not approved; and in its stead, on motion of Dr. Costello, the Board voted that it be considered inexpedient to take action on this matter at this time. The Welfare Committee's suggestion that the Society undertake to distribute to its members copies of *Administrative Procedures for the Medical-Surgical Plan* (see page 20 of the January JOURNAL) was approved except for the provision that the cost be borne by the Society. The following recommendation of the Welfare Committee was unanimously approved by the Trustees:

> "That press releases of the committees of this society be cleared through the Public Relations Sub-committee before copies are sent to the press."

* See third paragraph of report of Sub-committee on Legislation, page 66 of this JOURNAL for details of that conference.

The recommendation of the Sub-committee on Public Relations with reference to the State Health Congress (page 69, this JOURNAL) was approved. The Trustees also endorsed the Society's sponsorship of a state-wide public health week in the fall, this program to be a joint enterprise of the Sub-committees on Public Health and Public Relations.

PUBLIC HEALTH

The recommendation that "The New Jersey Venereal Disease Clinic Physicians Association become a part of The Medical Society of New Jersey" was disapproved pending clarification. All other recommendations of the Sub-committee on Public Health (see page 72, this JOURNAL) were approved.

The Trustees endorsed the suggestion that the Medical Practice Act be amended so that medical schools in Canada and Newfoundland be removed from the classification of "foreign schools".

MALPRACTICE INSURANCE

Dr. Costello reported for the special committee on malpractice insurance and the Trustees voted to authorize the committee to communicate directly with the central office of the insurance company with the aim of securing full and adequate malpractice insurance coverage for all members.

GRADUATE EDUCATION

Dr. Costello reported that graduate courses had started at the Cooper Hospital in Camden and that the program was working smoothly. Extension of the plan to other areas in the state is expected soon, depending on our experiences in Camden. It was announced that Rutgers University desired to establish courses in and for the county societies and that our Committee on Postgraduate Education has been designated as an advisory committee to Rutgers University in the development of their medical-educational plans.

RESOLUTION ON DEATH OF DR. NORTH

Dr. Green read the following resolutions on the death of Dr. Harry R. North, prepared by the committee appointed for this purpose. A copy has already been transmitted to the family of Dr. North.

HARRY R. NORTH
1878 — 1946

A skilled physician, a champion of the best traditions and ideals of organized medicine, a firm and true friend.

Quiet, unassuming, he worked long and hard for the cause of organized medicine, particularly as represented by The Medical Society of New Jersey.

The sound financial condition of our Society, as well as our fine home will long stand as a memorial to the diligence and faith of Dr. North.

During all the years of service to our Society he sought no glory for himself, save the personal satisfaction of a job well done and continually turned a deaf ear to any honor we would gladly have bestowed on him.

Therefore, be it resolved that this token of the esteem in which we, his colleagues held Dr. North be spread upon the records of the Society, published in the JOURNAL and transmitted to his bereaved family.

Upon motion by Dr. Scammell, seconded by Dr. Costello and unanimously carried the resolutions on the death of Dr. North were approved.

COMMUNICATIONS

Dr. Green read a communication from the Council on Medical Services of the A.M.A. asking for 3500 copies of the folder embodying the principles of cooperation between the county medical societies and the state and local health departments with reference to prenatal clinics, venereal disease clinics and Baby-Keep-Well stations. It is intended to distribute these in connection with an A.M.A. news-letter, since the project in New Jersey is generaly considered an example of effective cooperation between community agencies and the medical society. The Trustees approved.

The Board voted to ask the Veterans Administration to adjust urologic fees when the contract expires in March so that they might conform to the fee schedule recommended by the American Urologic Association.

The Trustees endorsed the Industrial Sight Conservation program drawn up by the State Department of Health and already approved by our advisory committees.

Dr. Schaaf moved that the matter of fees for care of wards of the State Board of Children's Guardians and beneficiaries of old age relief programs be taken up with the appropriate governmental authorities with the request that the fees be set at $2 for office visits and $3 for house calls. This motion was passed.

Dr. Green reported that ackowledgements had been received from the Bishop of Camden, the president of Rutgers University, the state Department of Education and Governor Driscoll. The Bishop of Camden asknowledged our endorsement of the project of the Diocese to provide additional hospital beds in the south Jersey area. The other acknowledgements concerned our resolution on the establishment of a medical school in New Jersey, detailed on page 14 of the January JOURNAL.

The meeting was adjourned at 5 p. m.

WELFARE COMMITTEE

JANUARY 12, 1947

MEMBERS PRESENT:

Dr. Hilton S. Read, Chairman
Dr. Royal A. Schaaf, Acting President
Dr. David B. Allman, Atlantic County
Dr. Edward H. Guion
Dr. D. Ward Scanlan
Dr. A. G. Pratt, Camden County
Dr. H. Wesley Jack
Dr. E. A. Y. Schellenger
Dr. Albert B. Kump, Cumberland County
Dr. J. Wallace Hurff, Essex County
Dr. Harrold A. Murray
Dr. Wendell J. Burkett, Gloucester County
Dr. Chester I. Ulmer
Dr. Vincent P. Butler, Hudson County
Dr. J. Lawrence Evans
Dr. Berthold S. Pollak
Dr. Hugh H. Tyndall
Dr. Philip W. Baker, Hunterdon County
Dr. Barclay S. Fuhrmann
Dr. Samuel Blaugrund, Mercer County
Dr. Walter E. D'Arcy
Dr. L. Samuel Sica
Dr. John H. Rowland, Middlesex County
Dr. C. Byron Blaisdell, Monmouth County
Dr. Stanley Nichols
Dr. George B. Emory, Jr., Morris County
Dr. Homer H. Cherry, Passaic County
Dr. Joseph R. Jehl
Dr. Lewis C. Fritts, Somerset County
Dr. Frederick W. Lathrop, Union County
Dr. Hershell S. Murphy

CONSULTANTS:

Dr. Henry A. Davidson
Mr. John J. Debus
Mr. William H. MacDonald
Dr. Frederic J. Quigley

GUESTS:

Dr. Daniel Bergsma
Dr. Raymond A. Taylor
Dr. C. E. Weigele
Dr. Earl LeRoy Wood
Dr. A. Charles Zehnder
Dr. W. James Marquis
Dr. Asher Yaguda
Dr. Norman M. Scott
Dr. G. M. Knowles
Dr. Jerome G. Kaufman
Dr. S. William Kalb
Dr. William G. Herrman
Dr. A. Joseph Hughes
Dr. Charles I. Silk
Dr. James O. Hill
Dr. Joseph F. Londrigan
Dr. Edward T. Yorke
Mrs. Stephen Waterbury
Mr. H. G. Waltner

Chairman Read introduced Mr. Harry G. Waltner, Jr., Insurance and Society Security Department, Standard Oil Company of New Jersey, who spoke on cash sickness benefits. An abstract of Mr. Waltner's talk follows:

The matter which I have been asked to speak to you about is one of very great interest in New Jersey today. It is a subject on which legislation will be introduced at the next session of the Legislature, and probably passed. When we speak of cash sickness benefits, we are not referring to plans for medical care, treatment, or hospital services and facilities; we are speaking of weekly cash payments to sick individuals as partial reimbursement for the wage loss which they suffered by reason of their disability.

We all are in favor of protection for workmen for loss of earnings when they suffer disability and are unable to work. That does not necessarily extend to favoring compulsory legislation, and we are here to discuss the means by which legislation can be effected to provide compulsory programs of cash sickness benefits.

Four general plans have so far been offered for solving this problem. The first is *the Rhode Island plan*. It is a monopolistic system under which the state collects a tax from every worker; from the monies resulting from these tax revenues, the State proposes to pay benefits to individuals when they are unable to work because of disability. A modification of that is *the California plan*, which is basically the Rhode Island plan with a contracting-out provision. This permits employers or groups of employees to be excluded from the state system providing they operate under a private plan whereby greater benefits are available than those provided for in the state plan. The third type is what may be called *the New Jersey proposal* and is incorporated in the "Fourth Report of the State Commission on Postwar Economic Welfare". Under that program there is no state tax collected and there is no state benefit paid to any individual; but there is a legal liability placed on employers for loss of earnings because of non-occupational disability or sickness. The employer may proceed to insure that risk with any approved insurance company; or he may set up his private program and handle it as a benefit payment plan. The role of the state is then merely that of supervision. The state determines whether the private plan meets the minimum specifications set forth in the act. If a worker feels he has not been treated fairly with respect to any benefit he may appeal to a referee to determine whether he is entitled to benefits; and if so the employer is required to pay the benefits decided. The program, of course, contemplates that there can be appeals to the courts. The third function of the state in this plan is to determine which employers are included. All of these plans follow the Unemployment Insurance laws in their coverage. In other words, employers who are sub-

ject to the Unemployment Compensation laws in that state, would be obligated to protect their employees against this risk.

The *fourth type of plan,* not yet in existence in any state, is a modification of the New Jersey proposal. It would contemplate that in addition to the employer having the option of his own insurance plan (or insuring with any approved company) that the state would set up a competitive insurance fund. Any employer who chose to do so could proceed to take out his insurance with this competitive state fund in which the contribution is made to the state fund and the benefits would be payable from that state fund. It is similar to the arrangement in effect in New York on workmen's compensation.

The only system on which we can express any opinion is the Rhode Island plan because it is the only one which has been in effect long enough to know anything about it. The Rhode Island plan is a compulsory program applicable to all those covered by the Unemployment Insurance Act. Each one of those workers, is entitled to the benefits on a scale which is comparable to the benefits paid for unemployment. One result of the enactment of that law has been the withdrawal of private plans from operation in Rhode Island. The state plan in Rhode Island pays between 60 and 70 per cent of earnings. Accordingly, with that amount of benefit payable, the administrative costs and other factors render it impracticable for any insurance company to underwrite such a plan. Employers with private plans find it impracticable to continue their private plans for the reason that benefits under the state plan represent such a high proportion of wages. The Workmen's Compensation costs have increased substantially in Rhode Island since this state benefit for sickness is payable *in addition* to Workmen's Compensation awards. Workmen's Compensation represents 65 per cent of wages, the cash sickness benefit is another 65 per cent, with the result that the individual receives about 130 per cent of wages when he is sick. It is very profitable to be ill in Rhode Island.

Contrary to all other experience, the benefit payments in Rhode Island are the highest in the summer months. Under all private plans, the greatest amount of compensable illness occurs during the winter. And in Rhode Island, they have had to increase their tax from 1 per cent to 1½ per cent.

So far as California is concerned, we have no experience on which to draw. They have corrected to a degree some of the difficulties of the Rhode Island plan. They do not pay maternity benefits nor sick benefits in addition to Workmen's Compensation. Duration of payments is limited to 150 per cent of the duration of payment of unemployment insurance. Under the Rhode Island plan they can draw their full compensation benefits and become ill and draw another full spread of benefits for illness. Rhode Island started out by not paying these benefits in addition to Workmen's Compensation; but before the benefit payment plan became effective, employees went to the state legislature and said they were paying the tax and felt that they should get this as well as the Workmen's Compensation benefits.

The New Jersey proposal clearly represents the program which is most consistent with our free enterprise system. And the Rhode Island plan presents a social philosophy which is utterly inconsistent with it. There is no obligation on the part of this state to take care of individuals when they are ill. The obligation is placed upon the employer. The philosophy of the Rhode Island plan is that it is the duty and obligation of the state to provide for these welfare payments. In the New Jersey report, factors have been considered which do not appear in any other survey of this subject. There are four basic principles which the Commission has recommended as the basis upon which they frame their report and recommendations.

The first is "The conditions accompanying the economic results of non-occupational accident and sickness benefits vary greatly among industries and among companies within each industry. A publicly supervised program offers the suitable flexibility to meet these needs." The New Jersey proposal is the most flexible plan which could be recommended, for an employer and his employees can cooperate and they can work out a program which they believe meets the needs of that group. A survey conducted by the New Jersey State Chamber of Commerce indicates that 112,000 employees are operating under uninsured plans. Some 190,000 are operating under insured plans. Approximately 89 per cent of the employees are receiving this compensation without any cost to them. Rhode Island would require each one of those to pay $45 a year for something he is getting free today. Thus, it is entirely possible under the New Jersey proposal for financing to be worked out between employers and employees to meet the problems and conditions of the particular company or industry involved. Under the New Jersey proposal it is possible for them to vary their program much more than is possible in Rhode Island, for duration of benefits, for amount of weekly benefits and for waiting period and other factors.

The second basic phase is "The employment relationship is vitally affected by the scope and character of a cash sickness benefit program. Companies which wish to extend additional effort to minimize the financial hazards of accident and illness among employees should be permitted to have the advantage in personal relationships that accompany such effort". Employers have found that cash sickness benefits are one means by which that relationship can be placed on a more satisfactory basis. Any system which provides for payment of benefits by the state to the individual injects the state between the relationship of the employees with the workers in any company, and it prevents good employer-employee relationship from being utilized to obtain one of the objectives which are certainly necessary if we are going to have any industrial peace in this country.

The next phase seems to be this: that under either the Rhode Island or California plan with state tax, there is no credit given either to the employer or employee for measures taken jointly or individually to maintain the good health of an employed group. It is a state tax that everyone has to pay. Many

companies are doing much with heavy expense to themselves to aid the employees to good medical care and educating them as to the desirability and need of taking care of themselves. Under any program except the New Jersey one, the employer and employee get no credit financially for any steps taken to keep the employee on the job and in good health. The New Jersey proposal recognizes that those expenditures have a direct bearing upon the amount of days lost because of sickness and accordingly the employer and his employees who are involved in the program receive direct financial benefit.

"Government should not intervene in the employment relationship unless the need and conditions are beyond the capacity of private enterprise. Thirty years experience in New Jersey with workmen's compensation justifies confidence in the ability of private enterprise to administer effectively a sickness benefit program". Certainly we have the precedent in New Jersey of leaving this problem to the realm of employees and employers in our workmen's compensation program. We have no state fund, monopolistic or competitive, in the state of New Jersey and it has been found private enterprise has been fully able to meet the problem. There is no reason to believe that the same arrangements cannot work in a cash sickness benefit program.

The fourth phase is: "A publicly *operated* program which of necessity must offer minimum benefits tends to establish the maximum benefits. This is because the cost of offering benefits, beyond those provided in the publicly operated plan, is so great per dollar of benefit that employers are discouraged in attempting to provide additional benefits". In a state program providing for a fixed amount of benefit the minimum becomes the maximum benefit which the worker receives when the incident of disability occurs. On the other hand where you have a privately operated plan the standards which are set forth in the law being flexible do not have that influence and accordingly the worker can fare much better under the New Jersey proposal than they would or could fare under the Rhode Island or California proposal.

CHAIRMAN READ: These significant remarks by Mr. Waltner on the subject which is certainly bound to have great impact on the future of the practice of medicine in this country are now open to discussion.

DR. QUIGLEY: Last March the legislature directed the Commission to consider this matter and offered a bill which would have set up a state operated plan. At that time, on behalf of the Legislative Committee, I submitted a memorandum in which we stated that organized medicine was in favor of cash sickness benefits. In 1938 the A.M.A. House of Delegates went on record as being in favor of cash sickness benefits, and again last year reaffirmed that position. The question is not whether we are in favor of cash sickness benefits. The question now is the *method* by which these plans are to be put into effect. We recommended that it be made obligatory on the part of employers to carry some form of cash sickness benefits. The recommendation of the Commission was to that effect. Under this recommendation it will be obligatory upon the part of all employers to carry a cash sickness benefit of minimum standards. It does give the employers, many of whom pay full benefits, (and in other cases where employees pay part) the right to continue those voluntary payments. One point that muddied the pond considerably was that at the last session of Congress the Social Security Act was amended so that where employees pay money into Unemployment Compensation funds, (and that is the case in New Jersey) that portion of the employee's contribution could be made available by the state for the payment of cash sickness benefits. By the end of 1946 the employee's contributions to the Unemployment Compensation fund in New Jersey approximated $180,000,000; labor immediately became vociferous and asked that this matter be reconsidered by the Commission to make available this fund or part of it. In November there was another hearing. Again we submitted a memorandum to the effect that we were in accord with the recommendations of the Commission and the fact that there was $180,000,000 available should not influence the basic consideration of the Commission.

The important thing that I see from our standpoint is this: that for the moment the Murray-Wagner-Dingell bill is dead—it will be for the next few years, but some form of compulsory medical service is not impossible in the future and we know in countries like England, where cash sickness benefits have been tied up with medical care, a terrible mess has been made. We should do everything we can possibly do to put into effect legislation which will bring about an effective program for cash sickness benefits along the lines recommended by the Commission on Post-War Economic Welfare.

VETERANS EXAMINATION UNITS

DR. LONDRIGAN: The plan is already operating in two counties—Monmouth and Hudson. Contracts have been submitted to VA in Washington by the corporate plans of Middlesex, Essex, Warren-Hunterdon, Ocean, Morris, Passaic and Bergen. Union has signed its contract. Mercer, Cumberland, Salem, Gloucester, Atlantic and Burlington have adopted the proposal and have been urged to submit their contracts promptly. Atlantic has been apprised of the need for covering the Cape May area, should this be necessary . Camden and Somerset will not be ready by January 15.

With the next week, formal contracts with VA and Middlesex, Essex, Warren-Hunterdon, Morris, Passaic, Bergen and Ocean should be in the hands of the Newark Regional Office, as I have learned that their contracts have been forwarded. VA will then have facilities for pension examinations in an area covering sixty-six per cent of the veterans in New Jersey.

Mercer and Union will raise this to eighty per cent.

The Liaison Officer, Dr. Yorke, has emphasized the need for completing the total organization of the counties as soon as possible so that he may take all back-logged cases from VA and have units to send them for completion.

Valuable experience has been gained in the operation of the Hudson plan, which now has five units. Giving the clinicians all x-ray and laboratory reports for their consideration at the time of their examinations has resulted in the making of a high type of report, the very thing desired by VA for rating purposes. Use of the *Manual for Examining Physicians* gives the clinician information as to what the VA Rating Board desires.

Use of the IBM Service Bureau for maintenance of financial accounting for each plan has reduced the operation to the factor of getting the veterans and physicians together for the examinations. The unit clerk arranges for the examinations and returns the completed reports to the Liaison Officer. One physician acts as a chief medical officer during the examinations.

It has been recommended that the examining physicians give ten per cent of their fees to their plans to assure an adequate reserve for administrative purposes. There will be no individual complications, since this will be done automatically with the machine records system.

Volume of "business" seems to be a cause for delay, for our relations with VA in Washington have been most cordial. The Newark Office states that it cannot use the facilities of the various plans until formal contracts have been received by that office. I have maintained almost daily contact with the Liaison Officer in the development of our plans and am happy to report that we have the situation well in hand.

I wish to take the time to thank the members of the Central Committee, Drs. Herrman, Wood, Lloyd and Allman, for the magnificent results now being manifest as a result of their effort in appraising their areas on the nature of the program.

Dr. Yaguda: How do they handle the x-ray and laboratory work in Hudson County?

Dr. Londrigan: That is handled entirely by the hospital.

Dr. Read: I do not see how the roentgenologists and pathologists can be included in the plan.

Dr. Allman: This is only for pension examinations not treatment.

Dr. Herrman: We are not setting up these clinics for the benefit of the medical profession. We are setting them up primarily to help the veteran and to help the VA. We are being paid good fees, but it is impossible to set this up so that every doctor in every part of the state gets an equal break on it. I am against hospital practice of medicine as much as any one present, but the whole idea of these clinics is that the veteran be not taken away from his work. A man will be examined, so far as possible, at the hospitals where clinics have been established. Each county can settle this for itself. In Monmouth County, all the x-ray work that can be done while the veteran is there, is done at the hospital. We must face this problem as: first, a service to veterans; second, a service to the VA; and third, a service to the doctors.

Dr. Yorke: I have been asking VA since the first of September for a job to do. I explained we had a very efficient organization and were prepared to do whatever they would desire. Dr. Fagley said that he planned to give us 7,000 cases a month. I made an analysis after I gave the copy to The Journal and found that the back-log in VA did not even come to 30,000. I took my analysis to Dr. Fagley. I wanted him to read it carefully and write us a reply to my analysis. Since that time I have it, as a matter of fact, from the official who schedules the examination, that there is no back log. Yet, in two months, VA may get a request to examine 60,000 veterans. In that case, VA will not be able to do the job. As I have gone from county to county I have changed my tune from a very big load to none at all. I have apprised the doctors of the situation that even though we may get only ten cases this month we may get a thousand next month; that we need an organization to examine veterans for pension; that we should not think about load. VA cannot tell us and we should stop asking them. We want to establish our own organization to give VA the services at requests. We have already established in one county units which have already completed examinations and the results have been so far superior to anything VA has ever seen. By using a central organization to coordinate, the final result is a credit to us, not like the stuff that was coming in to VA, sent in by individual physicians, resulting in poor diagnosis, things hanging in the air. The moral reason to me is bigger than any other reason. All our counties are coming along very nicely. But something to protect our own organization is most important and such protection is afforded by the value and quality of the reports rendered to the Veterans Administration.

On motion, seconded and carried, the report of the Veterans Liaison Committee was approved.

SUB-COMMITTEE ON LEGISLATION

Dr. Burkett read the report (see page 66, this JOURNAL) which was approved by the Welfare Committee. The question of a new act which would create county or part-county health units was then raised. If the act were passed, such units would receive state aid provided that the local areas concerned desired the creation of such county or part-county units. The bill concerns rural health in the fourteen small counties and does not apply to the first or second class counties at all. It does not conflict with nor supplant any phases of the projected reorganization bill.

DR. QUIGLEY: There is sufficient permissive legislation on the statute books at present to permit creation of regional health units by municipalities getting together and forming those districts. The objection has always been raised that it is an "invasion of home rule" to attempt to set up county health districts. This corresponding bill which has been operating for six months in New York state has already had beneficial effect. The philosophy is not that of imposing progress from the top. These health units would be brought into being only upon requests of municipalities to their Boards of Freeholders. They in turn ask establishment of such units on the part of the Department of Health. The incentive for the creation of these health units is that the state would pay 50 per cent of the administrative costs. As it is now drawn, the bill would provide only for application to counties outside of first or second class counties and there is excellent reason right now for the passage of some such bill.

Under the Hill-Burton Hospital Construction Act passed last year, provision was made for public health centers. Public health centers are not defined in the bill but to maintain and operate them would certainly require much larger health units than these individual boards of health. I think there are some 576 separate municipal boards of health in this state. The bill offers a method for making possible better health administration in a way which is not antagonistic to the people directly concerned. This is not for the moment a legislative matter. It is a public health bill.

DR. MURRAY: I would suggest that this item be put on the agenda for the next meeting. It seems to me all right and in line with our philosophy. There is only one thing we have to consider—the terms of the health officer is not fully defined and probably not restricted to a physician. There have to be seven members on the Board, three of whom will be physicians.

DR. QUIGLEY: It has been proposed that this bill be introduced under the auspices of the New Jersey Health and Sanitary Association. If it is intended to have any action on this bill at this session it will be too late to consider at the next regular meeting. If it is possible for the bill to go in and then to be referred to the Public Health Committee certainly there will be no trouble getting it amended if there are objections or exceptions. If you wait until the next meeting to take any action on it, it will be too late.

Dr. Nichols moved that representatives of the Public Health Committee and the Legislative Committee meet with the Board of Trustees and be given power to act on this matter so that it will get before the legislature with our endorsement. This motion was seconded and carried.

SUB-COMMITTEE ON PUBLIC HEALTH

Dr. Blaugrund read the report of the Subcommittee on Public Health which appears on page 72 of this JOURNAL. All recommendations were approved by the Welfare Committee except as follows:

The recommendation that the state furnish penicillin to physicians for treatment of syphilis was referred to the Medical Practice Committee with instructions to invite a pharmacist to take part in their deliberations on this proposal. The suggestion that we endorse routine chest x-rays in general hospitals was also referred to the Medical Practice Committee.

SUB-COMMITTEE ON PUBLIC RELATIONS

The report of the Sub-committee on Public Relations (printed on page 68 of this JOURNAL) was read by Dr. Sica. All recommendations suggested in that report were adopted by the Welfare Committee.

SUB-COMMITTEE ON MEDICAL PRACTICE

The report of the Sub-committee on Medical Practice (printed on page 73 of this JOURNAL) was read by Dr. Zehnder. Except as indicated below, all recommendations of that Sub-committee were approved by the Welfare Committee. The status of hospital radiologists was discussed at length, and in that connection, Dr. Marquis made the following remarks:

The intent of our recommendation is to explore the possibility of common discussion between the hospitals and The Medical Society. The aim would be to work out a more uniform plan. In some cases an individual radiologist has problems with reference to his large hospital board and perhaps we

could help him. It was thought that we could do something if we could get some disinterested persons to give the matter a little time and look at the problem from, perhaps, a different angle.

Dr. Herrman suggested that a group of men, —physicians who were not radiologists—might make a disinterested study of the problem and propose an ethical arrangement.

It was voted that the matter be referred to the Trustees of The Medical Society of New Jersey with a recommendation that they investigate and communicate with the N. J. Hospital Association with the aim of presenting and discussing the ethics of relationships between doctors and hospitals.

The Welfare Committee voted to recommend that we assume our share of the expenses incident to publication of a fifth edition of the *New Jersey Formulary*. In connection with the "Newark Medical Clinic", Dr. Schaaf made the following comments:

That was taken up with the Medical Examiners and we investigated it and so far as the legality of practice is concerned it is quite in the clear. The question is whether we have an example of corporate practice of medicine. That has been referred to the counsel of the Board of Medical Examiners for opinion as to the legality of such practice. His report has not been received but we expect to have it for the next meeting of the Medical Examiners. We have been aware of this in Essex County and the matter has been taken up with the doctor who has been working at the clinic. He is willing to do what the Essex County Medical Society tells him to do. But nothing can be done at the moment until we get a formal expression from the counsel of the State Board of Medical Examiners.

Upon motion the meeting was adjourned at 5:00 p. m.

SUB-COMMITTEE ON LEGISLATION

REPORT TO WELFARE COMMITTEE, JANUARY 12, 1947

FEDERAL LEGISLATION

Under the new streamlining of committees of the Congress, the Committee on Education and Labor of the Senate has been replaced by the Committee on Labor and Public Welfare. In the present Congress, Senate health bills will be referred to this committee, of which Senator Taft of Ohio is Chairman. Our own Senator H. Alexander Smith is a member of this committee, as is also Senator Ball of Minnesota.

These three members were the sponsors of a bill introduced in Congress last year, known as the National Health Act, which served as an offset to the Wagner-Murray-Dingell Bill. A revised version of the Taft-Smith-Ball Bill (S. 2143) will soon be introduced in the Senate. It will probably be the most important health measure with which organized medicine will be concerned at this, and perhaps at the next session of Congress. Senator Taft has expressed himself to the effect that it would probably take two years to pass this bill.

As a result of an invitation from Senator H. Alexander Smith, originally extended to Dr. Samuel Alexander, the immediate Past-President, and subsequently extended to include Dr. Frederic J. Quigley, Executive Secretary of the Committee on Legislation, Dr. Thomas W. Harvey, President of the Essex County Medical Society, Dr. George Blackburne and Dr. Norman M. Scott, representatives from our Society were afforded an opportunity in Washington on December 28th to present certain suggestions with respect to the new draft of this bill. At the conference were Senators Taft, Smith, Ball and Donnell. Representatives of the New York Academy of Medicine also participated. The previous day, December 27th, representatives of the American Medical Association conferred with this Senate group with respect to the bill.

In view of the fact that Dr. Alexander is well acquainted with Senator Smith, it was felt that it would be more effective if our suggestions at the conference were made by him. Prior to this meeting careful examination was made of all sections of the bill and the suggestions which Dr. Alexander presented — and very well—were those which had been previously agreed upon. Dr. Quigley and Dr. Scott participated in the subsequent discussion of our proposals.

We expressed ourselves as in accord with the general philosophy of the proposed bill and with its two major proposals: (1) to place all medical and health activities of the federal government in a single agency, and (2) grants-in-aid to states which are in need of federal assistance to make available improved medical services "for families and individuals with low income". We suggested that the importance of public health warranted, in our opinion, a National Department of Health, to be headed by a secretary who should be a member of the cabinet; and if this were not feasible at this time, we endorsed heartily the creation of a National Health Agency.

As to grants-in-aid to the states we sug-

gested that this matter be re-examined with the thought of limiting such grants to states which can demonstrate their inability to meet this need without federal assistance.

In the creation of the National Health Agency it is proposed to include within the Agency all the present various medical and health activities of the federal government. Among those so placed would be the Public Health Service, the Office of Maternal and Child Health, Food and Drug Administration, etc.—seven in all—and "such other constituent units as the administrator finds necessary". In the bill as presently written the administration of "general medical services for families and individuals with low income" would be carried out by the Surgeon General of the Public Health Service. Here it was suggested that the National Health Agency contain as one of its constituent units the Office for Medical Services for Families and Individuals with Low Income. The further suggestion was made that this office be headed by a director who should be a physician who had had experience in private practice. At the time of the conference we learned that this idea had already occurred to the sponsors of the bill, and had also been suggested the previous day by representatives of the American Medical Association.

One of the provisions prescribed for a satisfactory state plan was "health inspection services for all children in elementary and secondary schools within the state". We are all aware of the perfunctory manner in which health inspection of school children is carried out in some localities, and we therefore suggested that there be substituted for the words "health inspection" the words "periodic physical examination".

In the section dealing with the advisory council to the Office of Maternal and Child Health it is incumbent upon this advisory council to consult with the head of the Office of Maternal and Child Health. We suggested that this situation be reversed, and it be made obligatory for the head of the Office of Maternal and Child Health to consult with the advisory council.

Hospital Survey and Construction Act — This bill became law at the last session of Congress and under its provisions each state will receive varying amounts to conduct a survey of existing hospital facilities and needs, as well as to construct hospitals and public health centers. The State Department of Institutions and Agencies has been designated to conduct the survey and establish state plans for hospital construction in New Jersey. In conformity with the terms of the act Commissioner Bates recently appointed an advisory council of twenty-five members, seven of whom, we are glad to report, are members of The Medical Society of New Jersey.

It may be that the Wagner-Murray-Dingell Bill will be reintroduced at this session of the Congress, but with the new complexion of Congress we feel sure that this measure could not possibly pass in the next two years.

STATE LEGISLATION

We do not know whether a bill will be introduced again to reorganize the State Department of Health; we suspect it will, because the women's groups were active prior to the November election, sending questionnaires to all candidates endeavoring to enlist support for the point of view that they exhibited toward this measure last year.

There are two measures which we understand will be introduced which will be reported upon today by other committees: (1) A bill to make possible the creation of county or part-county health units which would receive state aid, and which would be brought into being only upon request of the municipalities desiring the creation of county or part-county health units. We believe that report will be made upon this proposal by the Public Health Committee. (2) A bill to revise the Nursing Practice Act and to control "practical nursing" will be reported upon by the Medical Practice Committee.

Last year two bills were introduced to permit graduates of unapproved medical schools to take examination for licensure. One was designed to aid veterans only, who were residents of this state. The other bill would have included others as well. It is likely that similar bills will be introduced at this session, and accepting the attitude of the Society last year with respect to these measures we shall, of course, do our utmost to defeat them.

On December 12th we received a communication from the Secretary of the Board of Medical Examiners stating that the Board would like to have the Medical Practice Act amended: (1) to provide that major surgery can be performed by interns and residents only under the supervision of a licensed practitioner, (2) to give the Board control over private hospitals licensed by the Department of Institutions and Agencies, and (3) that Canadian schools be removed from the category of foreign medical schools. In reply to this communication we asked, with respect to (1), what section of the Medical Practice Act the Board would suggest be amended; we also asked for

a definition of major surgery. As to (2) we expressed the opinion that there should be professional control over hospitals not accredited by the Council on Medical Education and Hospitals of the A.M.A., or the American College of Surgeons, but before considering any legislation we suggested that this matter be taken up by the Board of Medical Examiners with the Department of Institutions and Agencies. We concurred (3) in the opinion that Canadian Medical Schools should not be regarded as foreign schools. However, we asked for information as to the Canadian attitude toward graduates of American schools. We are awaiting further advice from the Board as to these matters.

Cash Sickness Benefits—A bill to provide cash sickness benefits to individuals unemployed by reason of illness or disability, we feel certain will be introduced at this session. Inasmuch as the Welfare Committee, at today's meeting, has already had the advantage of exposition of this subject by Mr. Waltner,* suffice it to say that since organized medicine is on record in favor of the principle of cash sickness benefits, (such position having been taken by the House of Delegates of the A.M.A. in 1938 and reaffirmed last year) the position that our Society should take, with respect to legislation incorporating this principle, depends upon the policy or method of providing these benefits. At both hearings on this subject before the Commission on Post-War Economic Welfare, March 8, 1946, and November 21, 1946, we advocated the utilization of all voluntary plans now in effect, but making it obligatory upon the part of employers to provide an acceptable plan of cash sickness benefits. The position that we advocated, therefore, is similar to that of the conclusions reached by the Commission, which favored a state *supervised* plan instead of a state *operated* plan. We recommend that whatever influence we may have shall be exerted toward attempting to bring into being a plan which would provide cash sickness benefits in accordance with a state *supervised* program.

B. S. Pollak, M.D., Chairman
Sub-Committee on Legislation.

SUBCOMMITTEE ON PUBLIC RELATIONS

JANUARY 12, 1947

The Subcommittee voted to continue the *Health Hints* column. This project costs about $70 a week, and some questions had been raised as to whether we got our money's worth out of it. We send out 250 releases a week, and about sixty newspapers and house organs use our column. This is a coverage of 25 per cent which is excellent, since the usual coverage for an unsolicited release is only about ten per cent. The name of The Medical Society of New Jersey is repeated week after week in these 60 publications and it is, we think, a worthwhile publicity venture. The files of the Committee show that in a period of ten months we have received 56 letters from laymen who wrote to us because they had read the column and had a question to ask. If 56 citizens took the trouble to write, it may be assumed that a hundred times that many actually read the column.

The Subcommittee recommends continuing the column on the same basis.

AMA CENTENNIAL BROADCAST

New Jersey failed to get any place at all on the AMA centennial broadcast. Our state was included with Pennsylvania, Delaware and Maryland in one district. Each state was asked to name a doctor of the past whose life work could be dramatized. We nominated Dr. Henry Coit. Dr. Bauer of the AMA indicated that he was reluctant to accept New Jersey's nominee and finally chose Dr. Howard Kelly of Baltimore, characterizing this as an arbitrary choice. The Subcommittee felt that New Jersey's role in this program was not offered in good faith. Dr. Bauer himself said that in an area where Pennsylvania is located, it would be "unfortunate" to do a broadcast without using a Pennsylvania subject. The Subcommittee will ask our Board of Trustees to write to the AMA Trustees protesting against this treatment of New Jersey.

DIRECT COMMITTEE RELEASES

At the November 24 meeting of the Trustees, the Public Health Committee made the the following request:

> "The chairmen of the various subcommittees desire the privilege of releasing to the press their various activities and proposals."

The Trustees granted this request and in accordance with that grant, the Advisory Committee on Mental Hygiene did release some

* See page 61 this Journal.

publicity directly, without processing it through the Public Relations office. The Subcommittee on Public Relations now asks for clarification. It is believed that the privilege was extended to the writing of publicity material, but that clearance through the Public Relations Committee was contemplated. Technically, the privilege was extended by the Trustees to subcommittees and not to advisory committees. In any event, it seems poor administrative practice for advisory committees to short-circuit the proper public relations channels, and it is suggested that the advisory committee chairmen who want to release their own publicity do so by first clearing the copy informally through the Chairman of the Subcommittee on Public Relations. Even a telephone call will suffice, but unless some such procedure is followed, every committee, advisory committee, and subcommittee will be preparing and distributing releases independently and without any effort to conform to general pattern of the Society's public relations philosophy.

STATE HEALTH CONGRESS

The State Health Congress is now functioning, though still on an organizational rather than an operational level. The Trustees have assigned to the Public Relations Committee, the Society's participation in the State Health Congress. Dr. Nichols, temporary president of the Congress, proposed that the Congress set up a study group, made up of representatives of the Governor's office and of Princeton and Rutgers Universities. This study group should then make a survey of the distribution of health care in New Jersey. It was felt that operating the project under such auspices would remove any suspicion that the Congress was simply a front for the Medical Society. This was important because both the state Federation of Labor and the state C.I.O. indicated skepticism about the Health Congress. Both these labor bodies seemed to feel that the Congress was simply to be a voice for The Medical Society. Dr. Nichol's proposal was endorsed by the subcommittee and he was empowered to present it to the Health Congress meeting on January 15.

NEWARK RADIO STATIONS

Dr. Schaaf called the sub-committee's attention to the fact that the two major newspapers in Newark had just been authorized to set up radio stations. The Newark *News* had already asked for a health program, a half hour a week for 26 weeks. It was expected that the Newark *Star-Ledger* would soon make a similar proposal. The Essex County Medical Society is willing and able to furnish speakers for such a program and the cooperation of the state society is being asked. The subcommittee voted to approve this program and offer its facilities in furnishing speakers and writing scripts when necessary.

STATE HEALTH WEEK

We have been informed that the Public Health Subcommittee was recommending a state health week in the spring of 1947. It was suggested that this be a joint project of the Subcommittees on Public Health and Public Relations. The Welfare Committee is asked to approve this project and to ask the Trustees for the necessary funds.

PROMOTION OF M. S. P.

Dr. Scott brought up the question of the role of the Society, and particularly the Subcommittee on Public Relations in promoting the Medical-Surgical Plan. Certain technical difficulties were handicapping Dr. Scott in releasing his own publicity, and it was felt that since M.S.P. was so much an enterprise of this Society, it would be proper for us to help the promotion. Dr. Scott had written for the January JOURNAL (See page 20) a guide to administrative procedure for physicians participating in M.S.P. and he solicits the cooperation of the Society in distributing this. The Committee voted to ask the Tustees to permit the use of Medical Society clerical facilities for the mailing out of this administrative guide, in the form of JOURNAL reprints, to every member of the Society. While the M.S.P. is willing to assume the cost of this promotion, the Subcommittee felt that it was more properly a charge against the general budgets of the Society and so recommends.

L. SAMUEL SICA, M.D.,
Chairman.

HOSPITAL NAMED FOR DR. POLLAK

Dr. Berthold S. Pollak, Chairman of the Subcommittee on Legislation of The Medical Society of New Jersey, has been honored by his home county of Hudson, which has officially announced that the Hudson County Tuberculosis Hospital is being renamed the Berthold S. Pollak Hospital for Chest Diseases.

HADDON HALL PREVIEW

181st ANNUAL MEETING

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Atlantic City in the spring is the setting for the 181st Annual Meeting of The Medical Society of New Jersey. Note that this year's convention is a month earlier than usual. While program details are still incomplete here is the score to date:

The Place—Haddon Hall, Atlantic City.

TUESDAY, APRIL 22

11:00 a. m.—House of Delegates
2:00 p. m.—General Session
8:00 p. m.—Reference Committees
8:30 p. m.—Nominating Committee

WEDNESDAY, APRIL 23

9:30 a. m.—Scientific Sections
12:30 p. m.—Election, House of Delegates
1:00 p. m.—Group Luncheons
2:00 p. m.—Scientific Sections
6:15 p. m.—Mennen Cocktail Party
7:30 p. m.—Banquet

THURSDAY, APRIL 24

10:00 a. m.—General Session
1:30 p. m.—House of Delegates

Room Reservations: Forward reservation requests at once to Mr. Philip E. Parlett, The Haddon Hall, giving expected date and time of arrival. Rates $7 to $10 for single rooms and $10 to $18 daily for double rooms.

WOMAN'S AUXILIARY

The 20th Annual Meeting of the Woman's Auxiliary is scheduled as follows:

The Place — Haddon Hall, Atlantic City.

The Days — Tuesday, Wednesday, Thursday, April 22, 23, 24, 1947.

The Time —	Tuesday	10:00 a.m.—Registration and Reservations.
		1:00 p. m.—Executive Board
	Wednesday	9:30 a. m.—Business Session
		1:00 p. m.—Luncheon
		3:00 p. m.—Business Session
		6:15 p. m.—Social
		7:30 p. m.—Banquet
	Thursday	10:30 a. m.—Executive Board

SCIENTIFIC SECTIONS

Wednesday Morning, 9:30 a. m.—Surgery, Obstetrics and Gynecology, Radiology, Gastro-Enterology and Proctology

Wednesday Afternoon, 2:00 p. m.—Medicine, Pediatrics, Eye, Ear, Nose and Throat

SURGERY

Congenital Atresias of the Alimentary Tract

Robert E. Gross, M.D., Ladd Professor Children's Surgery, Harvard Medical School, Boston.

Discussors: Edward W. Sprague, M.D., Newark.
Irvin E. Deibert, M.D., Camden

Traumatic Aneurysms and Arterio-venous Fistula

Harris B. Shumaker, Jr., M.D., Associate Professor of Surgery, Yale University School of Medicine, New Haven.

Discussors: H. Wesley Jack, M.D., Camden
Stuart Z. Hawkes, M.D., Newark

Diagnosis and Treatment of Carcinoma of the Prostate

Joseph C. Birdsall, M.D., Professor of Urology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Discussors: Meredith F. Campbell, M.D., Montclair
Charles H. deT. Shivers, M.D., Atlantic City

OBSTETRICS AND GYNECOLOGY

The Rh Factor in Obstetrics and Gynecology

Philip Levine, M.D., Director, Biological Division, Ortho Research Foundation, Raritan.

Discussor: Lyman Burnham, M.D., Englewood

The Use and Abuse of the Endocrines in Obstetrics and Gynecology

Abraham E. Rakoff, M.D., Endocrinologist, Jefferson Hospital Laboratories, Jefferson Medical College, Philadelphia.

Discussor: Rita S. Finkler, M.D., Newark

The Diagnosis and Management of Endometriosis

Franklin L. Payne, M.D., Professor of Obstetrics and Gynecology, University of Pennsylvania, Philadelphia.

Discussor: Hammell P. Shipps, M.D., Camden

RADIOLOGY

The Roentgen Findings in Functional Disturbances of the Gastro-Intestinal Tract

Paul C. Swenson, M.D., Professor of Radiology, and Willis F. Manges, Jr., M.D., Jefferson Medical College, Philadelphia.

Discussor: W. James Marquis, M.D., East Orange

GASTRO-ENTEROLOGY AND PROCTOLOGY

The Unstable Colon

S. Bernard Kaplan, M.D., Chief of Gastro-Enterology, Beth Israel Hospital, Newark

Discussors: Isaac Gelber, M.D., Elizabeth
Eugene Merliss, M.D., Bloomfield

Pruritis Ani: A Bio-Chemo-Physiologic Problem

Harry E. Bacon, M.D., Professor, and Clifford E. Hardwick, M.D., Associate Professor of Proctology, Temple University School of Medicine, Philadelphia.

Discussors: Frank S. Forte, M.D., Newark
Julius Gerendasy, M.D., Elizabeth

Allergy in Relation to Gastro-Intestinal Diseases

Albert F. R. Andresen, M.D., Brooklyn.

Discussors: Joseph D. Goldstein, M.D., Jersey City
Theodore Heineken, M. D., Bloomfield

MEDICINE

Protein Therapy

Max Strumia, M.D., Associate Professor of Pathology, Postgraduate School of Medicine, University of Pennsylvania, Philadelphia

Discussor: Frank W. Konzelmann, M.D., Absecon

Recent Advances in the Diagnosis and Treatment of Heart Disease

J. Scott Butterworth, M.D., Associate in Medicine, Post-Graduate Medical School, Columbia University, New York City

Discussor: Louis F. Albright, M.D., Spring Lake

The General Practitioner and Diseases of the Chest

Oswald Jones, M.D., Associate Clinical Professor of Medicine, College of Physicians and Surgeons, New York City

Discussor: William E. Wakeley, M.D., East Orange

PEDIATRICS

Newer Concepts and Treatment of Haemophilus Influenza Meningitis

Hattie Alexander, M.D., Attending Pediatrician, Babies Hospital, New York City

Discussor: Horace Bell, M.D., Belleville

Metabolism and Feeding of the Premature Infant

Samuel Z. Levine, M.D., Professor of Pediatrics, Cornell University Medical School, New York City

Discussor: Chester R. Brown, M.D., Arlington

EYE, EAR, NOSE AND THROAT

F. Johnson Putney, M.D., Philadelphia

SUB-COMMITTEE ON PUBLIC HEALTH

REPORT TO WELFARE COMMITTEE, JANUARY 12, 1947

Meeting of Sub-Committee on Public Health, January 12, 1947, State Society Headquarters, Trenton.

Present were: Dr. Blaugrund, chairman, Dr. Nichols, Dr. Jaffin, Dr. MacKenzie, Dr. Sherman, Dr. McKiernan, Dr. Reading, Dr. Kalb, Dr. Kaufman, Dr. Blaisdell, Dr. Hill, Mr. MacDonald, Mr. Bebus, Mrs. Waterbury and Dr. Bergsma. Also present upon invitation were Dr. Murray, Dr. Guthrie, Dr. Magee and Dr. Weigele.

EXPANSION OF STATE DEPARTMENT OF HEALTH

Dr. Bergsma, Deputy Director of the State Department of Health, presented a statement and proposed budget relative to the expansion of the activities of the State Department of Health. Each member of the Committee has received a copy and one is on file in the Executive Offices. The report urged that key personnel in the Department (Venereal Disease, Industrial Health, Tuberculosis and Public Health) "ed." be absorbed on the State Budget, rather than having them paid from funds supplied by the Federal Government. The program includes creation or expansion of divisions of Epidemiology, Geriatrics, Nutrition, Public Health Nursing, Mental Health, Cancer, and local health units in rural areas.

Upon motion by Dr. McKiernan, seconded by Dr. Hill and unanimously carried the program offered and budget suggested were approved, and it was directed that it be forwarded to the Welfare Committee for action.

VENEREAL DISEASE CONTROL

Dr. McKiernan, Chairman of the Advisory Committee on Venereal Disease Control, presented the following recommendations from his Committee:

1. *Teaching of Sex Hygiene in the school system.*

In the discussion the following suggestions were made: that the course to be offered be given some other name, such as Education for Family Life; that local school districts work out their own course of instruction, the subject matter to be under supervision of The Medical Society of New Jersey; that the subject be resolved on a local level; that there be included in the program the training of students in the State Teachers' Colleges.

Upon motion it was directed that the matter be left in the hands of Dr. McKiernan and Dr. Guthrie of the State Department of Education.

2. *Venereal Disease Reporting.*

That there be recommended better reporting of contacts and sources of infection of V. D. by general practitioner.

Upon motion, seconded and unanimously carried the above recommendation was approved.

3. *V. D. Section at the Annual Meeting.*

Upon motion, the recommendation was referred to the Annual Meeting Committee.

4. *Clinic Physicians Association.*

That the New Jersey Venereal Disease Clinic Physicians Association become a part of the Medical Society and be recognized as such.

Upon motion by Dr. Murray, seconded and unanimously carried, the above recommendation was referred to the Board of Trustees.

5. *Free Supply of Penicillin.*

Recommendation to State Department of Health—That the Department supply P.O.B. to all physicians in New Jersey for treatment of early syphilis of not more than one year's duration.

Following discussion relative to the principle of supplying drugs free to physicians for treating venereal disease patients regardless of ability of the patient to pay, Dr. Murray moved that the matter be referred to the Welfare Committee without recommendation from the Public Health Committee. Seconded and unanimously carried.

6. *Mazzini tests.*

Recommendation to State Department of Health—That a diagnosis of syphilis not be made unless two Mazzini tests, taken not less than two weeks apart, are both four plus.

Upon motion by Dr. Jaffin, seconded and unanimously carried the above recommendation was approved.

PUBLIC HEALTH WEEK

Chairman Blaugrund asked for an opinion relative to The Medical Society of New Jersey sponsoring a Public Health Week in the spring, with a program to be worked out by the Public Health Committee and the Public Relations Committee, to include newspaper releases, radio broadcasts and programs before the Service Clubs.

Upon motion by Dr. Kalb, seconded and unanimously carried, the sponsoring of a Public Health Week by the Medical Society, at the same time as the National Public Health

Week, proclaimed by the President, was approved.

TUBERCULOSIS COMMITTEE

Dr. Jaffin, Chairman of the Advisory Committee on Tuberculosis presented the following resolution:

Whereas it has been long recognized that there is a high incidence of tuberculosis in general hospitals and other non-tuberculous hospitals, and that this has been recognized by the American Hospital Association, the United States Public Health Services, and the National Tuberculosis Association, in their recommendation that all hospital and clinic admissions should be x-rayed,

Resolved, that we recommend chest x-ray screening of all hospital and clinic patients as a routine public health measure, and urge endorsement of this recommendation by The Medical Society of New Jersey and its component county societies.

Upon motion, seconded and carried the above resolution was approved.

CARDIO-VASCULAR DISEASES

Dr. Kaufman, Chairman of the Advisory Committee on Cardio-Vascular Diseases, reported that of the 89 questionnaires relative to cardiac facilities, sent to New Jersey Hospitals, 85 had been returned. In the entire state there are 26 cardiac clinics, and only 18 of these are approved. A more complete report will be presented at the next meeting of the Public Health Committee.

COMMITTEE ON NUTRITION

Dr. Kalb, Chairman of the Advisory Committee on Nutrition, reported that his Committee would sponsor a page in the JOURNAL describing three vitamin or mineral deficiencies, followed by a case history. Readers will be asked to send in opinions of the deficiencies involved in this particular case. The replies will be published in the following issue of the JOURNAL.

SUB-COMMITTEE ON MEDICAL PRACTICE

JANUARY 12, 1947

Members present were: Dr. A. Charles Zehnder, who presided in the absence of Dr. Morris, Dr. Andrew C. Ruoff, Dr. Herschell S. Murphy, Dr. Asher Yaguda, Dr. Bror S. Troedsson, Dr. Chester I. Ulmer, Dr. W. James Marquis and Dr. William K. Harryman.

It was voted that a letter be sent to Dr. Watson B. Morris, chairman, expressing the sympathy of the committee for his illness and wishing him a speedy recovery.

INTERN TRAINING

Dr. Murphy reported on a joint meeting of the Hospital Relationships Committee of the Medical Society and the New Jersey Hospital Association held on December 11, 1946. Purpose of the meeting was to form a program for solution of the intern training problem in New Jersey. In the whole country there are 9,000 approved internships (including Army internships) and about 5,000 interns. In this state are two kinds of hospitals (a) hundred bed and over, which are approved by the A.M.A. for intern training; (b) seventy-five beds, which are approved by the State Board of Medical Examiners. Graduates of medical schools in Pennsylvania and New York are discouraged from coming to New Jersey to intern unless they enter the larger hospitals. Something must be done to raise intern training standards in the state, particularly in smaller hospitals, to encourage interns to apply in New Jersey for their training. It was suggested that the larger hospitals might "farm out" interns to the smaller hospitals to do specialty work. A committee, consisting of Dr. Murphy from the Medical Society and Mr. Hayhow from the Hospital Association, was appointed to condense the reports made by Dr. Schlichter in 1944 and 1945 and the New York Plan on Intern Training into a report to submit to the Boards of Trustees of the Medical Society and the Hospital Association for approval, and then arrange to have copies mailed to the hospitals which have approved internships for their reactions.

NURSING PRACTICE ACT

Dr. Zehnder informed the committee that a meeting had been held with representatives from the New Jersey Nurses Association and the New Jersey Hospital Association. The nursing profession in New Jersey is anxious to have control over practical nurses and is preparing a revision of the present act. Instead of defining the minimum requirements for practical nurses, (which is very difficult to do) they want to include in the Act a provision that from time to time The Medical Society of New Jersey, the New Jersey Hospital Association and the New Jersey Nurses Association should agree upon the requirements, so that it would

be possible to modify them administratively without frequent legislation.

INDUSTRIAL CLINICS

Dr. Harryman read a communication from the New Jersey Manufacturers Association on approval of industrial clinics. After discussion Dr. Harryman moved that inasmuch as it was not the policy of the Medical Society to approve clinics run by organizations, the matter needed further investigation, and recommended that the communication be referred to the Welfare Committee for assignment to the proper policy-forming committee, and then referred back to the Medical Practice Committee.

WORKMEN'S COMPENSATION

Dr. Harryman stated that he had received letters from several county societies urging an increase in compensation fees for office and home calls. He recommended that this be referred to the Welfare committee for consideration.

Dr. Harryman informed the Committee that he has been working on a revision of the article "Workmen's Compensation and the General Practitioner" and the "Schedule of Disabilities", published in the September 1941 Journal, and expected to send it to the Journal within a week or two.

RADIOLOGY

Dr. Marquis reported that his committee met on January 8, and wishes to submit the following recomendations:

1. That the Society make a requisite of any cancer program that the experience of the tuberculosis control methods be remembered and the general practitioner be recognized as a key man in the program as outlined by the state cancer committee; that any program which would bypass the private practitioner (by having a hospital or other organization usurp the functions of the private physician) be condemned; that programs be developed with the aid of the general pratitioner in all counties and that the county societies be encouraged to develop methods of helping the private physician recognize cancer in its early stages. The committee feels that only in this way can the early recognition and treatment of cancer be successfully accomplished. To do this requires that more publicity be given the role of the general practitioner and less to the clinic. In the past, too much emphasis has been given to the part played by the hospital. Only a small part of the population can be handled through such clinics.

2. That the program for caring for the veteran be continued as it is working satisfactorily. The plan, advocated by some, whereby the hospital would give this service on a per diem basis is to be condemned. Under such a plan the quality of service would deteriorate since the hospital would give such service at a loss and could only do so by curtailing the quality of the medical care.

3. There still are some hospitals which take advantage of the radiologist in that the hospital makes a large profit from the professional skill of the physician-radiologist. This acts to the disadvantage of all physicians. It is recommended that the Welfare Committee present a plan whereby such abuses can be studied and a report be given suggesting a way in which such defects may be corrected.

PHARMACEUTICAL PROBLEMS

Dr. Ulmer reported that the Committee on Pharmaceutical Problems and the Committee on Professional Relationships of the State Pharmaceutical Association met in October and decided to publish a new edition of the New Jersey Formulary this year. The Fourth Edition appeared in 1941. It is planned in this new edition to include new formulas that have been tested at the New Jersey College of Pharmacy. Some of the formulas which appeared in the last edition will be deleted. The Joint Committee feels the publication of a new edition this year is timely since many of our members have returned to practice from military service.

The Medical Practice Committee unanimously approved the publication of the new edition, and asked Dr. Ulmer to present his request to the Welfare Committee for its approval.

NEWARK MEDICAL CLINIC

Dr. Marquis called the attention of the committee to a clinic operating in Newark. They use a type of equipment which has, it is claimed, "cleared up carbuncles immediately" and healed sprained ankles in three days". Since no one has been able to find out what equipment is used or how it operates Dr. Marquis asked that he be authorized by the Medical Society to go to the clinic and investigate.

Dr. Murphy suggested that a representative of the U.S.F. & G. accompany Dr. Marquis, and it was also recommended that the State Board of Medical Examiners be invited to participate.

It was voted that Dr. Marquis present this matter to the Welfare Committee.

WORKMEN'S COMPENSATION: THE INFORMAL HEARING

Henry A. Brodkin, M.D., Chief Medical Director, Department of Labor

During the 1945 session of the New Jersey Legislature, the Workmen's Compensation Act was amended so that benefits to injured workmen were greatly increased. The purpose was to raise benefits to workmen because of the increased costs of living; and this, of necessity, indirectly raised allowances for counsel fees. A controversy arose as to counsel and medical fees. To permit a fair analysis of this and other problems, the Commissioner of Labor, Harry C. Harper, appointed a committee to advise him on this matter. He chose two members of the New Jersey Bar Association, two members of The Medical Society of New Jersey, one member to represent the State Federation of Labor, one to represent the Congress of Industrial Organization, one to represent business and one from the State Chamber of Commerce. The Director and the Chief Medical Director of the Workmen's Compensation Bureau were requested to be present at all meetings of the Committee. On December 28, 1945, this Advisory Committee recommended that counsel fees should be left to the discretion of the presiding judicial officer, subject only to the limitation of the statute. In regard to medical fees, the Committee recommended that consideration be given to the qualifications of the doctor and the time and effort spent by the medical witness. The committee is still functioning and affords an excellent opportunity to critics of the administration of the Workmen's Compensation Act to come forth with constructive suggestions.

The Commissioner of Labor, Harry C. Harper, and the Compensation Bureau, have been and are receptive to any suggestions that would further the fairness and honesty of medical testimony.

As the distinction between formal and informal hearings may not be known to many doctors, the following explanation will be helpful:

An *informal* proceeding is held before a referee. Any injured person may present his claim to the referee in an informal manner. He may write a letter or appear at the referee's office with or without counsel. The claimant and his employer, or the insurance carrier, are notified to appear before the referee. At this time, a physician employed by the State, examines the injured person from an impartial point of view and makes the following recommendations:

1. Whether further treatment is necessary and temporary disability should be continued

or

2. Whether no further treatment is necessary and temporary disability has ceased

and

3. The degree of permanent disability if any.

These findings and estimates are immediately given to the referee to serve as a guide in advising the parties and arranging for an amicable settlement. The injured, the employer, and the insurance carrier, are under no obligation to accept the findings. Either side has the right of independent examination of the injured person and the privilege of presenting their respective reports of findings and disability of their own doctors. The latter statements may be taken into consideration by the referee in conjunction with the reports of the State doctor. Frequently, there are differences of opinion as to the amount of disability and the referee acts as arbiter in an effort to bring satisfaction to both sides. In this situation, a general practitioner and the respondent's doctor can be of great aid if they clearly state in their reports the how, when and where of the accident, the extent of the trauma, and the course of the healing period and the percentage of functional loss of the part. It is unusual for doctors to appear as witnesses at the informal hearings. Their written reports, however, are accepted and considered. The settlement is recorded after it is agreed to by both parties. In the event of a settlement, either side has the privilege of re-opening his case for re-hearing or filing a formal petition within two years from the date of the last payment of compensation, as to accidents, and one year as to occupational diseases compensable under our Act. The State doctor is greatly aided in arriving at a just conclusion when he has available to him all reports, pertinent laboratory data, and x-ray films.

Many physicians are reluctant to evaluate the percentage of disability because of a lack of experience and confidence in these matters. However, there exists no monopoly of special information or knowledge in medical compensation matters. It is purely a matter of understanding certain principles, practices and philosophies which long experience has established in the administration of this Act. Although it must deal in numerical values to establish a monetary award, there is no mathe-

matical certainty about it. It is a matter of medical and personal opinion. For example, a crushing blow of the hand or finger may result in a loss of function of 20 per cent in the opinion of one doctor or 30 per cent in the opinion of another. There is no formula by which one can with certainty say there is 25 per cent loss of function. However, the integrity of medical men suffers when one doctor estimates 10 per cent and another evaluates 75 per cent for the same injury. If there is a 25 per cent loss of function of the hand as a result of interference with its motor and sensory functions, the same evaluation holds true in the case of a laborer or a skilled mechanic or an accomplished musician.

If either party is dissatisfied with the recommendation of the referee, each has the right to file a formal petition. In this case, a *formal* hearing is scheduled before a Deputy Commissioner of the Compensation Bureau. Here the entire proceeding is recorded and sworn testimony is taken. The formal proceeding will be explained in a later issue of this Journal.

Although the informal hearing is not legally binding, it is considered a practical, quick and efficient way of disposing of many cases appearing before the Bureau. Indeed, the majority of cases are expedited in this manner. Studies are still being made with a view of improving this procedure.

NUTRITION IN EVERYDAY PRACTICE

PEDIATRICS AND NUTRITION

An Interview with

Stanley H. Nichols, M.D., Asbury Park, New Jersey

Q: Pediatrics is one of the most important branches of medicine. Many of the physicians would like to know the relationship of nutrition to pediatrics. Will you explain what practical measures you would suggest for improving the nutrition of children?

A: Continue improvement in nutrition education, beginning with the medical profession and other allied groups such as dental, nursing, pharmaceutical, etc. To educate the mother or the family in nutrition is a long range program. Many people have strong ideas implanted in them from the country of their birth and from the communities in which they live. It will take about twenty-five years to educate the people and to change racial and environmental habits. We ought to applaud the governmental agencies and the food companies for the splendid job they are doing in advancing education in nutrition.

Q: What do you consider a prophylactic dose of vitamin D in infants against rickets?

A: A thousand units. Four hundred units are recommended but I am not sure that the individual infant is standardized sufficiently to be affected by this small dose.

Q: What is your therapeutic dose?

A: Rickets is rare because physicians have been using the prophylactic dose and mothers have been giving their children cod liver oil. I use it up to twenty-one years of age. Subclinical rickets is still common and I use 1000 units a day.

Q: Is it your opinion that diarrheas in children are nutritional in origin?

A: Some diarrheas may be due to poor diets but they are largely due to parenteral infections and occasionally to excessively hot weather. Hot temperatures lower the child's resistence and subject him to diarrheas. This is still a major cause of death in the southern and Pacific countries where hot weather predominates.

Q: In an asthmatic child having an allergy to many foods there sometimes follows weakness and emaciation because of the withdrawal of these foods. Would a combination of amino acids and vitamin B complex help digestion and the cachexia?

A: Yes, when the diet is deficient. Hypoprotenemia exists and must be treated with amino acids or other protein foods. Not only in asthma but in any chronic disease of infancy or childhood.

Q: Do you think the neuroses of childhood are due to improper nutrition to any extent?

A: An undernourished child developes neuroses more easily because of the psychosomatic inter-relationship.

Q: Do you find many vitamin deficiencies in children?

A: I find about 66 per cent less than was evident twenty years ago. Today we don't see rickets and scurvy very much. This is in direct proportion to the amount of education that

the mother has received. One of the commonest defects is the removal of vitamin D during the summer because the sun in this climate is not sufficient to replace the vitamin D which is so necessary. Pediatricians give 1000 units in the winter and 500 units in the summer.

Q: How can schools contribute to better nutrition?

A: Two ways. One by teaching what an adequate diet is in detail. Education should start at the school cafeteria so that the children can see the actual combinations demonstrated. And to, have the children, cafeteria attendants, teachers and parents pass an examination on how to construct adequate diets.

Q: Do you find any objections to children eating candies or other sweets between meals?

A: Yes I do. Artificial sugar products reduces the appetite in children and the closer to a meal that they eat them the more the appetite is reduced. Chocolate is the greatest offender. Natural sugars such as found in oranges, prunes and milk do not have the same effect upon the appetite. Most pediatricians do not want children to receive milk at 10 a. m. but would much rather that it be given at the end of the school day when they can get some exercise so that the milk doesn't have any effect upon the supper. The 10 a. m. milk feeding interferes with lunch digestion.

Q: Do you prescribe any particular diet for stunted children?

A: It depends on what the cause is for slow growth, whether endocrine or dietary.

Q: Have any grown as the result of a prescribed diet?

A: Many. At least half of those above two years of age need an adjustment of their diets and we know from checking the weight and height at three month intervals that they do well. Exceptions occur in chronic infections or where there is need of mental hygiene in the family. This interferes with proper diet.

Q: How do you control weight in abnormally fat children between five and twelve years of age?

A: It depends on whether familial, endocrine or over-eating factors are present. I try to preserve the mental hygiene of the child by using low calorie foods and increase the amount of exercise. From birth until adolescence I try to get instilled in the mothers a feeling of cooperation and understanding. If there is 50 per cent cooperation on the part of the mother you will usually find about 25 per cent cooperation of the child. Obese children are more of a problem than the thin ones.

GRADUATE COURSES IN ESSEX COUNTY

Announcement is made of six new graduate medical courses under the joint auspices of the Essex County Medical Society and Seton Hall College. For further details and registration information, write to Dr. Gerald Cetrulo, Director, Medical Courses, 40 Clinton Street, Newark 2, N. J. The course in gynecology is given at the Seton Hall campus, Ward Place at South Orange Avenue, South Orange, N. J. All other courses are given at 40 Clinton Street in Newark. Physician-veterans who wish to take advantage of the "G.I. Bill of Rights" should submit certificate of eligibility at the time of application. All others should remit tuition fee check payable to "Seton Hall College".

SUBJECT	STARTING DATE	SCHEDULE	NUMBER OF SESSIONS	TUITION FEE
Biochemistry	February 26	Wednesdays 4 to 6 P. M.	12	$100.00
Gastro-enterology	March 5	Wednesdays 8 to 10 P. M.	10	75.00
Gynecology	February 22	Saturdays 3 to 5 P. M.	25	125.00
Hematology	February 21	Fridays 4 to 6 P. M.	6	60.00
Neuropsychiatry	February 18	Tuesdays 4 to 6 P. M.	15	75.00
Roentgenology	February 20	Thursdays 4 to 6 P. M.	12	75.00

NUTRITION AND PSYCHOSOMATICS

Herbert T. Kelly, M.D., of the Graduate School of Medicine, University of Pennsylvania, will address the Middlesex County Medical Society on February 19, on the subject *Nutrition Integration in Psychosomatic Medicine.*

Dr. Kelly is Chairman of the Committee on Nutrition of the Pennsylvania State Medical Society and an authority on nutritive therapy.

All physicians and others interested, are cordially invited to attend this meeting, which will be held at the Roosevelt Hospital, Metuchen, N. J., at 9:00 p. m., on Wednesday, February 19, 1947.

VETERANS CARE PLAN

E. T. Yorke, M.D.

The Central Veterans Liaison Committee discussed the ethics of physicians in their dealing with VA, on January 12. The conclusion was that physicians have an obligation to protect the reputation of the medical profession.

OVERTREATMENT

In New Jersey there are more veterans per thousand under treatment and more treatment visits per veteran than in either Pennsylvania or Delaware.

In an effort to modify this possible overtreatment without jeopardizing the veteran's interests, the Liaison Officer has recommended referal to him of requests for treatment which VA considers "out of line".

The system of asking physicians to state a given number of treatment visits anticipated for a month may have led some doctors to believe that all the authorized visits should be used up since VA authorized them. Physicians must understand that the veteran should receive *only the treatment found absolutely necessary,* regardless of the number of visits authorized.

Veterans are called into the Newark office of VA whenever there is the appearance that physicians are overtreating.

Requesting a definite number of treatment visits is an easy calculation for physicians in most cases. It is recommended that physicians keep their requests to the rigid minimum in conformance with sound practice.

NO FEE CEILING

A memorandum has been issued by Philadelphia Branch Office stating that participating physicians are not subject to the income limitation of $6000 per year as directed for designated fee-basis physicians.

FEE-BASIS ELIGIBILITY

The Liaison Officer has issued a statement to all county medical societies clarifying the affiliations of the physician in the VA medical care program. Eligibility of physicians is determined on the basis of membership in the medical society; no need exists for physicians to apply to VA to be appointed as designate fee-basis physicians. The contract between VA and Medical Service Administration stipulates that the Liaison Officer will certify the physicians.

COUNTY PLANS

An estimated seventy per cent of the veteran population of this state is now served by Plans in Monmouth, Hudson, Middlesex, Essex, Bergen, Ocean, Morris, Passaic, Warren and Hunterdon counties. Contracts made by these Plans with the VA in Washington are in the hands of the officials in the Newark Regional Office. Others made by Union, Mercer, Salem, Cumberland, Gloucester and Atlantic Plans are in process. These will give the VA practically state-wide coverage in facilities for accomplishing back-logged pension examinations.

Stating that the original objective of the Medical Society to recommend fourteen stategic units was totally inadequate, Dr. Fagley, Chief Medical Officer of VA in Newark, considered at least thirty units necessary to meet the needs. The Plans are now capable of establishing that number in eight counties alone. The organization is flexible, however, and is capable of meeting the needs of VA whatever they may be. The load is a minor factor in the program which has been developed by the Plans for the convenience of the veteran and examinations fit for rating.

Early experience with the five examining units in the Hudson Plan has demonstrated the superiority of the unit system over the previous method at VA's disposal of having a veteran visit several physicians at their own offices.

Dr. Edward Matthews, Chief of the Scheduling Section (medical) of VA, Newark, told me that the reports were uniformly excellent and a great source of relief to him, because it was his obligation to forward only reports suitable for rating purposes to the Rating Board.

Using the manual and having the laboratory and x-ray work available for the clinicians at the time of their examinations has caused well-coordinated reports in the Hudson units, which are located at the Jersey City Medical Center, St. Francis (Jersey City), St. Mary's (Hoboken), North Hudson (Weehawken) and Bayonne, Hospital.

NEW JERSEY STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH NEWS FOR THE PHYSICIAN

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

Preliminary figures on many communicable diseases reported to the State Health Department by local boards of health during the year 1946 are now available. These figures show decreases over the 1945 totals for poliomyelitis, scarlet fever, typhoid fever, undulant fever and whooping cough.

Diphtheria case reports increased from 140 (in 1945) to 250 (in 1946). The 1945 figure was the lowest ever recorded in this state. The increase which occurred in 1946 suggests that the program of immunizing children against this disease should not be allowed to lag and should be carried out even more intensively than in the past.

Poliomyelitis reports dropped from 952 (in 1945) to 257 (in 1946). Such a decrease is normally expected after a year of high prevalence.

Scarlet fever reports decreased from 4243 (in 1945) to 4191 (in 1946). This small decrease is not significant.

Rocky Mountain spotted fever reports showed little change. Eighteen cases were reported in 1946 against fifteen in 1945.

Tuberculosis reports increased from 3413 (in 1945) to 3621 (in 1946). It is likely that more widespread case-finding programs particularly through the use of the x-ray were potent factors in this increase.

Typhoid fever reports dropped from 80 (in 1945) to 60 (in 1946). Only once before (in 1943) has the annual number of reported cases been so small.

Undulant fever reports declined from 73 (in 1945) to 58 (in 1946).

Whooping cough figures showed 7043 cases reported against 7317 in 1945. It is hoped that more widespread use of immunization against this disease will result in a further decline in prevalence during 1947.

CHEST X-RAY SURVEYS INCREASE

The Division of Tuberculosis Control of the New Jersey State Department of Health is expanding its tuberculosis case finding program as additional equipment is received. The Division provides free chest x-rays for industrial employees as a case finding program. The 4 x 5 and 70 millimeter films are read by the medical personnel of the Division and all persons showing doubtful or positive findings are recalled for a large (14 x 17) film. At the time of the second x-ray, the name and address of the family physician is secured and a report of the finding is sent to him. Follow-up of the cases is made through the Bureau of Local Health Services of the Department by local health departments and tuberculosis leagues with the knowledge and consent of the private physician. In 1944 with one transportable x-ray unit in operation, 24,000 industrial workers were rayed. During 1945, the figure was 27,000. In 1946 an additional unit was available during the last three months of the year and over 52,000 industrial workers received free chest x-rays. The tuberculosis suspects and cases totaling 3,151 screened out during these surveys were referred to their family physicians for observation, consultation and medical care.

CITATIONS TO NEW JERSEY DOCTORS—Additional Names

On page 506 of the December, 1946 JOURNAL appeared a preliminary list of military and naval citations to New Jersey physicians. An announcement is made of the following additional names, about which the Editorial Office has just been informed:

CICCONE, Roy, Passaic ..... Commendation
LEFF, William, South Orange ..... Commendation
MACART, J. Harold, South Orange ... Navy Unit Citation
MOLITCH, Matthew, Atlantic City Commendation
NAGLER, Benedict, Newark ... Commendation
PROBST, Everett W., Lyndhurst Commendation
SMALL, Louis, Passaic ..... Bronze Star

COUNTY SOCIETY REPORTS

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

Regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, N. J., on December 10, 1946. It was called to order by the President DR. ALBERT W. CLOUD, at 9:15 p. m.

Speaker of the evening, DR. H. J. STANDER, Professor of Obstetrics, Cornell University Medical School, was introduced by Dr. Twinem. His topic was *Treatment of Pre-Eclampsia and Eclampsia.* He also presented interesting facts about other toxemias of pregnancy, especially, *Acute Yellow Atrophy* and *Obstetrical patients with nephritis,* which he classied according to severity. He presented interesting cases of post-partum eclampsia, occuring as late as seven days after delivery. The audience showed a great deal of interest in his presentation and participated in an active discussion of Dr. Stander's paper.

On recommendation of the membership committee, the following were elected to full membership: Dr. John Catapano, Ridgefield Park; Dr. John A. Sullivan, Teaneck; Drs. Jacob J. and Hildegard S. Vargish, River Edge; Dr. Reginald F. Seidel, Englewood; Dr. Harry L. Harwood, Palisades Park; Dr. Willima A. Pindar, Jr., Bergenfield were elected Associate Membership, and to Courtesy, Dr. Benjamin W. Carey, Westwood.

The president announced the death of DR. EDWARD W. CLARKE, of West Englewood, as of November 19th, and then requested the secretary to read the following resolution, which was adopted:

WHEREAS, God in His divine providence, has taken from among us our fellow member, Dr. Edward W. Clarke, and

WHEREAS, for many years he gave liberally of his time and ability for the welfare of this County, and was ever ready to help with all worthy County activities, now therefore

BE IT RESOLVED: That in the death of our esteemed fellow member, Dr. Edward W. Clarke, this County has suffered a great loss.

BE IT FURTHER RESOLVED: That this resolution be spread in full upon the minutes of this meeting and a copy thereof, signed by the officers of the Society, be forwarded to the family of the deceased.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The monthly meeting of the *Camden County Medical Society* was held on December 3, 1946, at the Camden City Dispensary with DR. HENRY B. DECKER, president, presiding.

DR. W. T. REED introduced the speaker of the evening, DR. EDWARD ROSE, Assistant Professor of Clinical Medicine at the University of Pennsylvania. Dr. Rose spoke on *Thyroid Diseasc.* He reviewed the recent trend in therapy of thyroid disease. He mentioned the advantages of thiouracil and propylthiouracil over iodine and the dangers of granulopenia (5 or 6%) and true agranulocytosis. This treatment is not yet a substitute for thyroidectomy.

Dr. Rose's subject was discussed by DR. HERMAN E. WIANT, DR. T. K. LEWIS, DR. HAROLD K. EYNON and DR. W. T. REED. In closing, Dr. Rose stated the prognosis was not as good in elderly people; that it was not safe to administer the drug after the patient had once had a toxic reaction. The Society gave a vote of thanks to Dr. Rose for his interesting talk.

Applications for membership were received from: Dr. Stanley Bernell, Dr. Dorothy Campbell, Dr. Robert Imhoff, Dr. Hammell Shipps, all of Camden, Dr. Albert Kay of Merchantville and Dr. Marie Russell of Collingswood.

DR. T. B. LEE reported on the Centennial Celebration. The Society voted the Committee be discharged and given a vote of thanks.

Dr. T. B. Lee, reporting for the Executive Committee, stated the incorporation of the Society was proceeding. The Cancer Society has requested rooms in the Dispensary. They want to cooperate with the doctors. The Society approved the action of the Executive Committee in granting their request.

DR. W. T. SNAGG, chairman of the Veterans Administration Committee, said the V. A. wants the clinic established in the hospitals only. They cannot procure equipment for the clinic. The hospitals are unable to carry this load of the Veterans Administration Clinic. Dr. T. K. Lewis suggested that publicity be given to the Society's offer to the Veterans Administration. Dr. Snagg's report was accepted by the Society. Dr. Shark moved that a report be forwarded to The Medical Society of New Jersey and to local veterans organizations. The Veterans Administration admitted that the Society's plan was good but said they cannot enter into it.

DR. A. G. PRATT read a proposed amendment to the Constitution which would make it easier for a member to be transferred to this society from another county society.

DR. I. E. DEIBERT, acting chairman of the Hospital Committee for the Catholic drive for the new hospital, asked support of all members. The hospital will be non-sectarian.

ESSEX COUNTY

Felix J. Di Fino, M.D., Reporter

An interesting and enlightening illustrated talk on, *Cancer of the Rectum, Colon and Terminal Ilium,* presented by DR. FRANK LAHEY, of the Lahey Clinic, was the feature of the combined meeting of the *Essex County Medical Society* and the *Academy of Medicine of Northern New Jersey* on December 13, 1946. The meeting was opened by DR. J. I. ECHIKSON, president of the Academy of Medicine, and was then turned over to the president of the Essex County Medical Society, DR. THOMAS W. HARVEY, who presided.

Dr. Lahey stressed the fact that the most impor-

tant feature for the surgeon treating any patient afflicted with cancer of the bowel is early diagnosis and radical resection. In 97.3% of cases treated at the Lahey Clinic, the patients showed changes in bowel habits, anemia, rectal bleeding and loss of weight. Dr. Lahey accentuated his views with a series of instructive slides which helped for a clearer understanding.

The following physicians were elected to membership in the Essex County Medical Society: Robert Brill, Reynold Burch, Marvin Fischman, Michael Hyland, Michael Klein, Leonard Leeds, Clifford Nelson, Herbert Peer, John Rocco, William Schram, Elmer Sevringhaus and Rudolph Warnecke.

GLOUCESTER COUNTY

D. R. Brewer, Jr., M.D., Reporter

Regular monthly meeting of the *Gloucester County Medical Society* was held December 19, 1946, at The Homestead in Woodbury, N. J. DR. LOUIS COLLINS presided.

It was decided that the January meeting be held at the Woodbury Country Club, as there would be more room available there. Drs. Francis Marion Brower and William Beall were elected to membership. Dr. Albert Bataglia withdrew application for membership in order to join the Philadelphia County Medical Society.

Speaker of the evening was DR. GEORGE GACKLER, Professor of Medicine at Hahnemann Medical College of Philadelphia who demonstrated the new methods of teaching auscultatory heart diagnosis to medical students. Through the use of a special microphone he had made recordings of the sounds of the valvular lesions of the heart. These recordings he replayed with a running comment on the types of heart sounds and their meanings.

Rest of the evening was devoted to open discussion of the pension examination plan to be set up for the Veterans Administration by the county medical society. The discussion was led by DR. EDWARD YORKE. The plan was approved and the incorporators designated. These are Drs. I. N. Patterson, Ralph Moore, Wendell Burkett, J. F. Hughes and B. A. Livengood.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting on December 3, 1946, at the Masonic Club in Jersey City. The meeting was called to order by the president, Dr. McNenney.

Following applicants were elected to membership: Dr. Dorothy L. Aymar of Union City; Dr. Morris B. Feldman, Dr. G. R. Kurtz, Dr. Joseph Giannasio and Dr. Walter Berlin, all of Jersey City; Dr. Mario J. Albini of Hoboken, and Dr. Merrill A. Swiney, III, and Dr. Nathan F. Troum of Bayonne.

Guest speaker, DR. FRANK L. MELENEY, Associate Professor of Clinical Surgery, Columbia University, College of Physicians and Surgeons, was introduced by the president. Dr. Meleney discussed *The Treatment of Surgical Infections with the Aid of Chemotherapy and Antibiotic Agents.* He explained the sulfonamides and antibiotics in the treatment of surgical infections, illustrating graphically the often dramatic results for which these agents must be given credit. He presented convincing evidence that judicious administration of these drugs, either by single or combined methods, as indicated, has been proved responsible for the avoidance of surgery in many cases, for less extensive surgery in many others, and generally, for more rapid healing.

Discussants of Dr. Meleney's paper were Drs. Quinn, Norton, Ruvane, Peters, J. D. Katz and I. Markowitz.

MIDDLESEX COUNTY

W. R. Greenwood, M.D., Reporter

DR. FREDERICK S. TABER of New Brunswick was elected president of the *Middlesex County Medical Society* for 1947, at the annual dinner meeting at Oak Hills Manor in Metuchen. Others elected were: DOCTORS EDWARD F. KLEIN, Perth Amboy, vice-president; OSCAR J. SOKOLOFF, New Brunswick, secretary; GEORGE J. KOHUT, Perth Amboy, treasurer, and W. RUSSELL GREENWOOD, New Brunswick, reporter.

Elected delegate and alternate to the state nominating committee, were Doctors C. Howard Rothfuss and Malcolm M. Dunham.

Elected to 3 year term to House of Delegates were: Doctors C. Howard Rothfuss, Malcolm M. Dunham, Benjamin Mann, Edward F. Duschock, Robert B. Walker, Marshall Smith, Benjamin Copleman, J. J. Lucey, Sol Gurshman, Murray B. Jacobson, Martley M. Howley and Gerard R. Gessner.

The program featured music by William and Richard Sherman, sons of Dr. W. Edgar Sherman of New Brunswick, and entertainment by Carlisle, noted magician.

MONMOUTH COUNTY

H. E. Jones, M.D., Reporter

On December 18, 1946, the *Monmouth County Medical Society* held its monthly meeting at the Monmouth Memorial Hospital in Long Branch.

DR. JAMES PREGNALL, president, introduced the guest speaker, DR. NELSON B. SACKET. Dr. Sacket is an associate attending Surgeon at Woman's Hospital and associate attending Obstetrician and Gynecologist at New York Hospital. He presented an interesting paper on *Conservatism in Diagnosis and Treatment of Pelvic Disease in Women.* The common signs and symptoms of pelvic disease were presented in outline. The bulk of the material was devoted to a more detailed discussion of the symptom pain. Case reports were presented for illustration of Dr. Sackett's statements. Conservatism in the treatment of sterility and vaginal bleeding was also explained in detail. Dr. Sackett closed his paper with a plea for conservatism. This conservatism may be watchful waiting or prompt action.

The business meeting began with a report on the commencement of the *Monmouth County Plan for the care of Veterans.* Dr. Herrman made a plea for the cooperation of all members of the society in an attempt to make it a success.

Dr. Holters presented a *Report of the Cancer Committee.* Much discussion followed.

It was voted to adopt the amendment to the Constitution and By-Laws. The amendment would include the last three presidents as *ex-officio* mem-

bers of the Executive Committee instead of the last president as it now stands.

Dr. Benjamin Goldstein of Asbury Park was elected an associate member.

OCEAN COUNTY

H. Rinzler, M.D., Reporter

Under the chairmanship of Dr. Raymond A. Taylor, its president, the *Ocean County Medical Society* held its regular meeting at the Sunset Cabin, Lakewood, N. J., on December 11, 1946. Members present were Drs. Taylor, Szold, Dodd, Carmona, Bunnell, Ivory, Hayden, Towbin, Rinzler, Sickels and Gable.

Two discussions were held under the heading of new business and two motions made. First, that it be recommended to the Boards of Education in the county that a member of the society, preferably a young veteran, be used as school physician in each of those localities now being served in that capacity by an osteopath or non-member; and second, that it be recommended to the local Boards of Health that examinations and blood-tests for all food-handlers be made compulsory.

The president then introduced Dr. F. S. Snegeriff who spoke on *Cancer Control*. Dr. Snegeriff pointed cut that the control of cancer as attempted by the American Cancer Society is a joint project of laymen and physicians, the former raising funds and the latter directing their expenditure. After national and state allocations have been made, the remainder is given to the county which then directs its own projects. In conclusion, Dr. Snegeriff emphasized the need for complete and thorough examinations as the first step in cancer control.

The Society then heard a short talk by Mr. Wm. Downs, lay chairman of the local Cancer Committee, followed by Dr. Wm. E. Dodd, medical chairman, who outlined the projected work based upon available funds, and asked for the society's cooperation.

UNION COUNTY

E. G. Bourns, M.D., Reporter

To the tune of more turf slinging than the English Steeple Chase, the annual Outing of the *Union County Medical Society* got underway at 2 p. m., September 18, 1946, at the Plainfield Country Club. About 1350 divots later, the 35 or so "golfers" staggered to the 19th hole. Caddies were plentiful but they were both busy. Jim Lyerly was low gross, but as usual a duffer named Lathrop got the prize.

As General Chairman, Jim Carlisle had worked out a very nice program for the evening. A delicious dinner was served to the tune of special accordian music by a professional.

Following the excellent food, we had a short business meeting called by President Lance, with the "rooler" in good working order. The UN should see how *we* settle problems. Then an hour of good entertainment—well mostly good.

Special door prizes were contributed by Ciba, Merck, Sharp & Dohme, Inc., Mead Johnson, Squibb, Carroll Dunham Smith Pharmacal Co., and Garret Byrnes and Sons, a surgical supply house in Orange. Added to these were a bunch of antiquated bits of equipment whose place as gifts added to the hilarity of the occasion. A good time was had by all.

Regular meeting of the *Union County Medical Society* was held on Wednesday evening, November 13, at the Elizabeth General Hospital with Dr. Lance, president, in the chair.

Dr. M. L. Griswold, Jr., chairman of the program committee, introduced Dr. Paul Reznikoff, Profes sor of Clinical Medicine, Cornell University Medical College, New York City, who spoke on *Blood Disorders of Interest to the Practitioner.*

Colonel J. H. M. Dudley, chairman, Welfare Committee, Union County Board of Freeholders, spoke briefly on the work of the public welfare committee and hospital needs for the indigent of the county. He also announced that fees to physicians caring for the clients of the Union County Welfare Board will be $2.00 for office calls and $3.00 for home calls as regular charges.

Applications for membership were received from Dr. Anthony Bruno, Elizabeth; Dr. R. A. Hall, Westfield; Dr. J. C. Hanrahan, Elizabeth; Dr. Joseph Judd, Jr., Elizabeth; Dr. P. P. Leone, Elizabeth; Dr. W. E. Martin, Cranford; Dr. Sol Pollack, Union, and Dr. C. J. Sager, Roselle. Members accepted by transfer: Dr. H. G. Dudley, Westfield, from The County of Kings, N. Y.; Dr. N. L. Heminway, Summit, from Somerset County, N. J., and Dr. Lucien Hirsch, Plainfield, from New York County, N. Y.

Candidates elected to membership were Dr. E. M. Coe, Cranford; Dr. R. T. Forsberg, Roselle Park; Dr. M. Eugenia Geib, Elizabeth; Dr. J. F. Giacoma, Union; Dr. D. C. Hackett, Westfield; Dr. S M. Hoch, Rahway; Dr. L. R. Kent, Rahway; Dr. J. G. Palin, Winfield; Dr. R. C. Pogge, Rahway; Dr. Stephen Repta, Union; Dr. Ascar Rozett, Summit, and Dr. J. J. Sheedy, Plainfield.

Dr. Runnells announced that the Union County Tuberculosis League wished to present to the Society a plan for x-raying all patients admitted to general hospitals and the League hoped for endorsement of this plan. He presented Dr. B. S. Pollak of Jersey City who spoke briefly on the plan.

A letter from Roselle-Roselle Park Medical Society was read, urging that compensation patients be charged the same rates as private patients are charged for similar services in Northern New Jersey.

It was moved that the county society adopt this recommendation and that this action be referred to The Medical Society of New Jersey. It was also moved that minimum fee for office calls be $3.00 and that house calls during the day be $4.00.

A new member from Union stated that he has been unable to get a hospital appointment and wished to know if the county society is in position to do anything about the matter. It was explained that the society can give information, but that pressure cannot be used on private hospitals to make staff appointments.

It was moved that the society authorize the Maternal Welfare Committee to approve the appointment of a county society member to the position of Field Physician of Union County.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE — AN INVITATION

Mrs. F. G. Wandall, Clayton, N. J.

A cordial invitation is extended to the wives, mothers and unmarried daughters and sisters of members of the Medical Society, to become members of the Woman's Auxiliary to the Medical Society.

There has never been a time in which the matter of health has been emphasized as at the present. There has never been a time when it was more necessary to present to the public our profession's viewpoint on matters affecting public health. The profession has in recent years been forced to wage defensive warfare against solutions which seemed to our physicians to threaten the progress of medicine and health services.

Through the Woman's Auxiliary much needed correct information concerning health can be and is presented to the public. It is true that as individuals, doctor's wives can, through membership in lay organizations, influence the policies of others. But by bringing together and combining many talents and capabilities, the aims of The Medical Society can be interpreted to other organizations interested in the promotion of health education, in a more forceful manner.

To you who do not enjoy membership in the Woman's Auxiliary, a special invitation is extended to attend the Annual Convention with your husbands, April 22, 23 and 24, in Atlantic City. Make yourselves known to our convention chairman and her committee. Attend the luncheon on Wednesday, April 23.

The Woman's Auxiliary is an active, stimulating organization; you will be glad you joined forces with us. "In unity there is strength". Let us be so strong and so forceful that no smallest opportunity to serve our Medical Society will pass us by.

EXECUTIVE BOARD MEETING

Mrs. Robert B. Walker, Chairman, Press and Publicity

The second Executive Board meeting of the *Woman's Auxiliary to the Medical Society of New Jersey* was held at the State Society Headquarters, Trenton, on January 13, 1947, with Mrs. Frederick G. Wandall presiding.

The morning business session was recessed, for a short period, to hear Dr. Harrold Murray, who spoke on *The Child Health Facilities in the State Instituted by Doctors.* He announced that questionaires will be sent to the doctors and ask that Auxiliary members be appointed to be responsible for them in their respective counties.

Following the luncheon served at the Carteret club, Dr. Frank G. Scammell, President of The Medical Society of New Jersey addressed the meeting. He urged, that the Woman's Auxiliary be built up to 100 per cent, because, in unity their is strength and by increasing the membership, their prestige will be augmented. He also asks that we give assistance to doctors returning from service whenever possible, and do all in our power to help them regain their practice.

Mrs. Luther J. Kice, chairman of legislation of the Woman's Auxiliary to the American Medical Society followed Dr. Scammell as guest speaker. She asks that we watch and understand the issues in legislation. We have tolerated many measures during the war; now we must struggle and fight bureaucracy. Study those bills concerned with health. This must be continued through the years; we cannot do it one year and relax the next. Work, watch and understand all new bills presented to the state legislature and congress. Bring the health issues before your various organizations and go armed with knowledge. We should go hand in hand with the medical profession to protect the health of the American people. As doctor's wives we do not exert our influence as we should.

Dr. Frederic J. Quigley, Executive Secretary of the Sub-committee on Legislation of The Medical Society of New Jersey, explained the health bills now before Congress. Dr. Quigley said, "Because the complexion of Congress is changed, it does not mean that we should relax our attention on medical bills." He considered the Taft-Smith-Ball bill one of the most important in the next two years.

Atlantic County

Mrs. Samuel L. Salasin,
Chairman, Press and Publicity

The *Woman's Auxiliary to the Atlantic County Medical Society* held their monthly meeting in the Chippendale Room of the Hotel Traymore on January 10, 1947.

Mrs. Charles Hyman, President, presided and asked for co-operation during the state convention and during the American Medical Auxiliary Convention to be held this spring. Mrs. David B. Allman, Chairman of both of these conventions gave us a skeleton program which will be detailed at a later date.

A cash donation was given to The National Foundation for Infantile Paralysis. Mrs. Anthony G. Merendino, co-chairman of Ways and Means announced that a card party will be held at the Hotel Traymore, in the Rose Room on March 12th, at 2 p. m.

Mrs. William O. Roop and Mrs. V. Earl Johnson, chairman and co-chairman of the February meeting anounced that a musical will be held at the Hotel Traymore, on February 14th, at 8:45 p. m. Artists for this affair are Miss Betty Wilson and Miss Mary Roop, vocalists, and Clarence Whims, pianist.

Mrs. Edward H. Dyer, Program Chairman for the evening with the assistance of Mr. Leon Leopardi of the Betty Bacharach Home presented a sound film *Home Safety* distributed by Woman's Division of Newark Safety Council. The story is by Joe Betzer and called attention to the fact that there are thirty-five million Americans in this country and that there are thirty thousand accidents, yearly resulting in deaths. The film shows that the kitchen is the most dangerous room in the house especially for children. It showed that play pens should be provided for babies and urged mothers to give children tasks to do such as setting the table while doing the cooking, thus preventing burn and scald cases. It pointed out that accidents occur when least expected. Smothering is a chief hazard for infants. Children's scissors should always have blunt ends.

Burlington County

Mrs. John C. Voss, Chairman, Press and Publicity

The Women's Auxiliary to the Burlington County Medical Society met for the first time this year on Monday, January 6, 1947, at a tea preceeded by a business meeting at the Zurbrugg Memorial Hospital.

The past year has been an active one in spite of the fact that the organization was deprived of the leadership of the president, Mrs. Dean H. LeFavor. She is a former president of the Auxiliary and well acquainted with the work of the state Auxiliary. Serious illness prevented Mrs. LeFavor from assuming the duties of president. Mrs. Anthony Ziccardi has been doing commendable work in her stead.

Six new members joined the Auxiliary in 1946. In addition to these, Mrs. Nathan Thorne, wife of Dr. Nathan Thorne of Moorestown, for many years a member of the Burlington County Medical Society, (now retired from active practice) was made an honorary member. Names of three new members were added to the files at this meeting. They were Mrs. John C. Whitaker, Riverton; Mrs. Edward Cicione, Palmyra; and Mrs. Alan Schaefer, Delanco.

A committee was appointed at the request of The Medical Society to meet with them to discuss new projects upon which the two organizations can collaborate.

A favorable report was made by the Pennsylvania Hospital School of Nursing on the progress of the student nurse sponsored by the Auxiliary. It has been the custom for many years for the Auxiliary to sponsor the training at an accredited school of nursing of some worthy applicant of Burlington County. Usually "Our Nurse" is a member of the graduating class of a Burlington County High School. She must have a high scholastic rating, a strong desire to become a nurse and unable to finance her training. The Auxiliary pays for her tuition, books and uniforms, and gives her a monthly allowance.

It is the sincere wish of the Auxiliary to obtain some other worthy project to sponsor in 1947.

At the conclusion of the business portion of the meeting, the members were addressed by Rev. W. Neal Raver, pastor of Epworth Methodist Church of Palmyra. Topic of his talk was *Getting a Kick Out of Life*. His address was humorous with a serious thought behind it.

Miss Marcella Johnson, accomplished young accordionist, entertained with several selections.

Tea and light refreshments were then served by the hostess, Mrs. George Wagner, superintendent of the Zurbrugg Hospital and a member of the Auxiliary.

Camden County

Mrs. Wilmer F. Burns,

Chairman, Press and Publicity

Dr. Ivor Griffith, President and Research Director of the Philadelphia College of Pharmacy and Science addressed *The Auxiliary to the Camden County Medical Society* at the regular meeting held January 7, 1947, in the Camden Woman's Club.

Four Challenging Signs was the speaker's topic. Dr. Griffith declared the home the first challenging sign as it is the center of the earth from which a child's education and discipline begin. Here self-control and reliance in faith is taught. He stated in order to reach the avenues of peace man must have intelligent optimism, then faith in tomorrow and finally, through richness and real achievement will earn one's way to the Kingdom of Heaven.

Mrs. Abram Kurtz of Merchantville entertained the group with four vocal selections and an excellent impromptu piano solo.

Twelve new members were accepted: Mrs. George Grenhart, Mrs. Thomas B. Lee, Mrs. Vernon Judson, Mrs. Ralph W. Gosper, Mrs. E. Walton Clark, Mrs. William J. Snape, Mrs. E. A. Schellenger, Mrs. Charles Driscoll, Mrs. Robert Bowen, Mrs. Ralph Wright, Mrs. Martin Swieclcki, Mrs. Harry Fredrich.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **February, 1947** **No. 2**

CHEST films of thousands of persons have shown lesions suggestive of early tuberculosis. Even though a fair percentage of these persons have had no tuberculin tests performed, no sputum examined, and no history of symptoms taken to confirm or deny the suspicious film findings, many of them have been labeled as tuberculous. This is scientifically unsound, and we should now take stock of our diagnostic criteria for the clinical determination of early tuberculosis.

WHAT IS EARLY TUBERCULOSIS?

Millions of people in the United States have been examined by means of mass radiography since the early days of World War II. This new technique is rapidly achieving the long-sought goal of X-ray examinations of the lungs of the majority of adults in our country. This objective can easily be reached within five years if all our resources are mobilized and a national plan is executed with speed and efficiency.

Yet a word of caution must be given to prevent indiscriminate diagnoses of pulmonary tuberculosis on the basis of X-ray examination alone.

Specialists in tuberculosis rightly insist that, before final diagnosis, every attempt be made to obtain sputum specimens, and that such specimens be submitted to meticulous examination by direct smear of actual or concentrated sputum and, if this be negative, by culture or guinea pig inoculation. If sputum is not present, a stomach washing should be made and the contents examined by appropriate culture methods in laboratories that employ skilled bacteriologists. In cases of pleural effusion, the same procedure should be followed. This is possible only in an accredited laboratory which has been certified by some impartial central laboratory.

If, after such diligent search, no tubercle bacilli are found, the diagnosis should be limited to "suspected tuberculosis." This does not mean that many of the shadows found on the survey films are not the residue of a tuberculous process that once was active. Nor does it mean that the person should not be followed for several years to observe new evidences of disease activity. Nevertheless, to be scientfic in our practice of medicine and to avoid needless distress, we should refer to such persons as "suspects" until such time as tubercle bacilli can be demonstrated. A firm stand of this sort should clarify confused thinking in mass radiography programs. To put it simply and candidly: do not diagnose pulmonary tuberculosis on the basis of an original X-ray film alone.

One must study "suspected" cases by means of a careful history, including recent or present symptoms which are characteristic of tuberculosis. For differential diagnosis it is essential to employ the tuberculin test, using the intracutaneous method properly applied and interpreted by an experienced person. In the presence of a negative tuberculin test, other reasons than tuberculosis must be found for suspected shadows, in spite of characteristic location and configuration. Indeed, even when a cavity is demonstrated on the film, a negative tuberculin test demands that some etiological factor other than tuberculosis be sought as the cause.

The same criteria used in diagnosis must be applied even more rigidly in the treatment of tuberculosis, especially sanatorium care and chest surgery. Persons whose chest films show shadows, discovered by mass radiography, should not be rushed into the sanatorium simply on the evidence of X-ray findings. A period of follow-up by the physician or clinic will determine the presence or absence of tubercle bacilli in the sputum, gastric contents, or pleural fluid.

Because a social stigma unfortunately attaches to a diagnosis of tuberculosis, and personal harm through mental anguish can occur, restraint should be practiced in naming the disease before its actuality can be proved. Even those persons whose diagnoses are confirmed will profit by a period during which they may become accustomed to the idea that they have a serious disease. Such a practice will keep expensive sanatorium beds free for patients who are truly ill and will avoid unnecessary exposure of nontuberculous persons sent to sanatoriums by mistake.

Persons who have tuberculosis which requires sanatorium care cannot be greatly harmed by short delay of treatment; in many instances the disease has been present for some time. The chest surgeon, too, should wait and watch with patience until tubercle bacilli are demonstrated as present in the lungs. This is particularly true of the too easily performed procedure of pneumothorax. Before the normal physiology of respiration is permanently changed by surgical attack, there must be strong evidence that such change and its attendant loss of function will be compensated for by the patient's future control of active disease.

There is yet no evidence in medical literature that the minimal lesion case with negative sputum, negative gastric lavage, or no sputum is benefited by sanatorium care. Rather it is a more realistic procedure to seek out and hospitalize the original positive sputum case which infected the minimal case so recently discovered.

We have placed emphasis in these remarks on the asymptomatic case with negative sputum or negative gastric contents. We must, however, be aware of and watch for "indolent" early tuberculosis. Caution is called for in the follow-up of early cases of tuberculosis that present vague findings and symptoms that are often difficult to elicit and interpret. This is the type of tuberculosis which British chest specialists call "indolent early tuberculosis," of whose prognosis we know little. Often such patients, when placed under sanatorium care, recover rapidly without surgical or special aid. Others deteriorate in the sanatorium in spite of the most expert medical skill and the finest facilities. One wonders if both types of cases would not have pursued the same courses undiscovered and unattended. We do not know why the body responds so indolently in these cases. Intensive investigation should help us find the answer, so that our follow-up program can be realistically directed and thereby be made more effective.

To sum up, no person should be labeled with the diagnosis of pulmonary tuberculosis on the basis of incomplete evidence. "Suspected tuberculosis" on the X-ray film must be corroborated by a positive tuberculin test and by positive bacillary findings. Let treatment be delayed and deliberated until all the facts are in and all the evidence is evaluated. If such a practice is followed, physicians will gain in accuracy and skill of diagnosis, and limited hospital resources will be conserved. Most important of all, the person suspected of having tuberculosis will be assured thorough study and scientific diagnosis and will be treated for tuberculosis only if the disease is actually present. Judgments based on positive and complete evidence will give a final verdict that protects the individual and the public health.

What Is Early Tuberculosis? Herman E. Hilleboe, M.D., Public Health Reports, September 6, 1946.

TREATMENT OF TUBERCULOSIS WITH STREPTOMYCIN

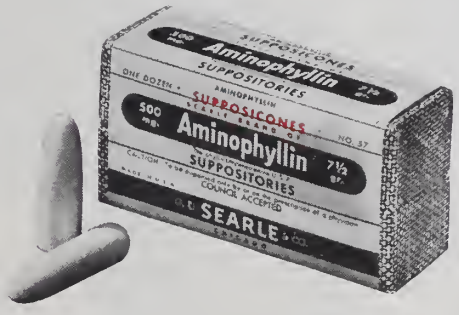
The Hinshaw, Feldman and Pfuetze report in the J.A.M.A., November 30, 1946, is up-to-date on this subject. By all means, read it, if you have not already done so.

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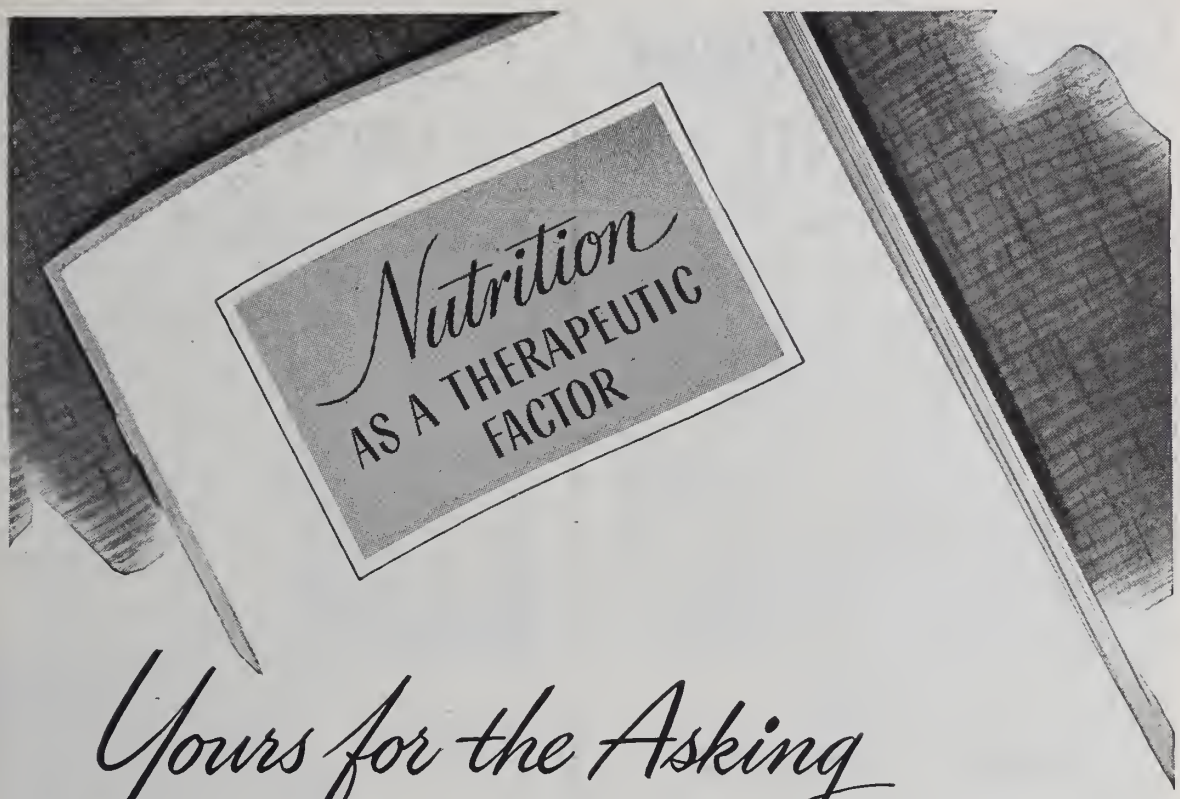
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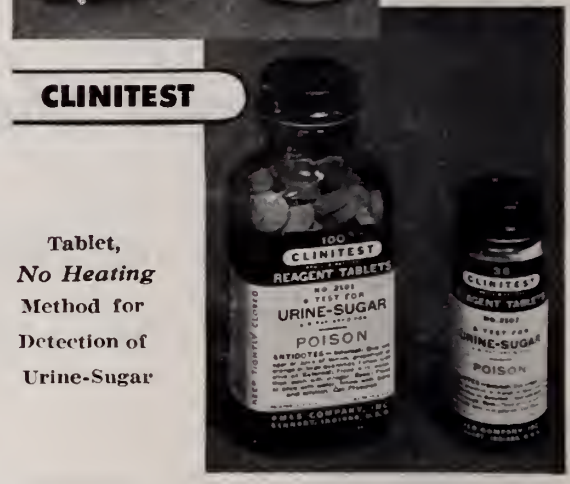
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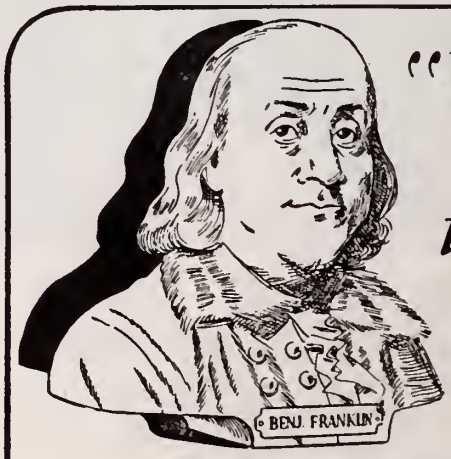
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1. Kugelmass, I. N.: Newer Nutrition in Pediatric Practice, p. 345, Lippincott, Philadelphia, 1940.

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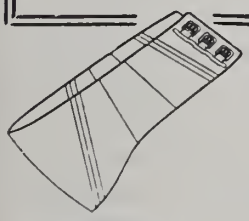
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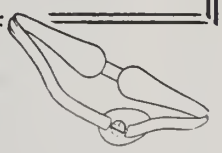
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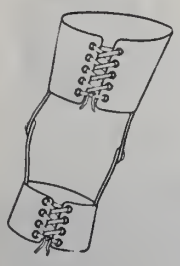




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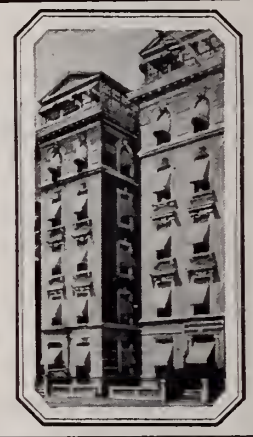
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The Cardiologist is assured of

Dependability in Digitalis Administration

Being the powdered leaves made into
physiologically tested pills,
all that Digitalis can do, these pills will do.

Trial package and literature sent to physicians on request.

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Full-Motioned, Lifelike

ARTIFICIAL HUMAN EYES





We have the Enviable Reputation of "Really Knowing How" to produce that "Pleasing Cosmetic Effect" so desired by one wearing an Artificial Eye.

REFERRED CASES CAREFULLY ATTENDED

IT IS OF VITAL IMPORTANCE TO THE PATIENT'S FUTURE APPEARANCE THAT THE FIRST ARTIFICIAL EYE BE PROPERLY FITTED. IT IS IN THESE NEW CASES, WHERE UTMOST ATTENTION MUST BE GIVEN—AND OF WHICH WE HAVE MADE A SPECIAL STUDY.

Especially Made to Order Eyes by Skilled Artisans.

Also Eyes Fitted from Stock.

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An investment in Picker X-ray equipment is an investment in consistently high performance over an exceptionally long life.

"It's all of seven years now since I bought this Picker Century . . . a 100 MA self-rectified job. It has served me well. But my practice, naturally, has grown over the years; so I'd been thinking of trading-in for a more powerful 200 MA set-up.

Then, one day, my Picker man came in with a great idea . . . a plan for converting my Century to full-wave operation, boosting it to 200 MA. Not trying to sell me a *new* machine, mind you, but making my *old* one "grow with me," so to speak. Of course I jumped at the idea; who wouldn't? Now I've got the 200 MA power I wanted . . . and all my old Century's flexibility and convenience to boot. I'm *twice* as well off as I was seven years ago."

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PICKER X-RAY CORPORATION
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PICKER

Century **full-wave conversion plan**

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"Nutritional Intervention"



All food essentials in optimal amounts are needed for the proper nutritional preparation of the surgical patient, as well as for his smoother convalescence. Under these conditions of urgency, the administration of GERILAC offers a highly effective means for providing these essentials in carefully balanced proportions and in easily utilized form.

Gerilac contains generous amounts of valuable milk proteins and the milk carbohydrate, lactose. The fat content is reduced and GERILAC is amply fortified with a full allowance of each of the vitamins and minerals. Convenient to prepare, GERILAC is highly acceptable in beverage form—and may be incorporated in a variety of recipes suitable for surgical and special diets. *Write for Professional Literature and Tasty Recipes booklet.*

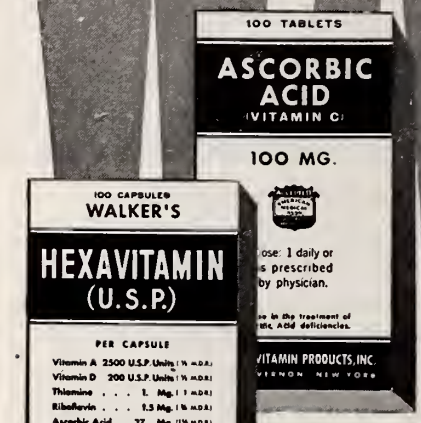
BORDEN'S PRESCRIPTION PRODUCTS DIVISION • 350 MADISON AVENUE, NEW YORK 17, N. Y.

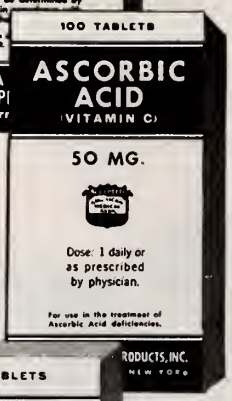


Gerilac

A Dietary Supplement for the Aged and Convalescents. GERILAC *contains spray-dried whole milk and skim milk and is fortified with vitamins A and D, B-complex, C, together with niacinamide, monosodium phosphate and iron citrate. Available at professional pharmacies.*

WALKER



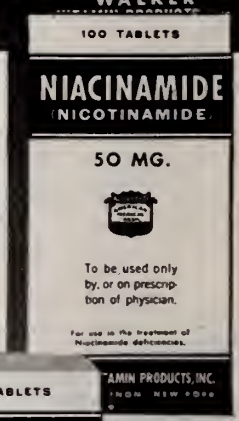


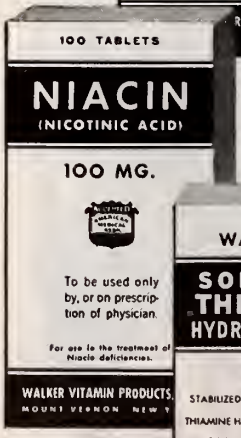


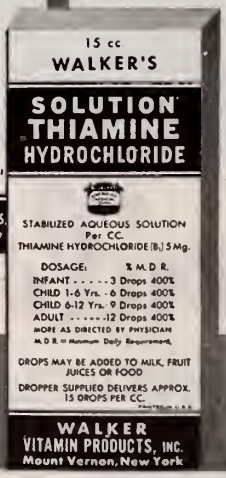
CONFIDENCE

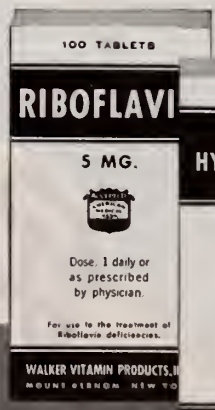
The hallmark of Walker manufacture is its uncompromising emphasis on quality. Rigid controls at every stage of production, from raw materials to the finished products, insure their dependability. Physicians know that Walker vitamin products can be prescribed with confidence.

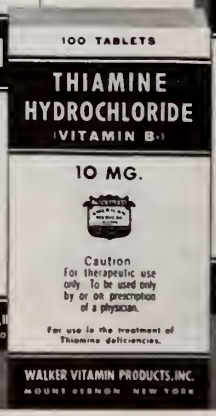
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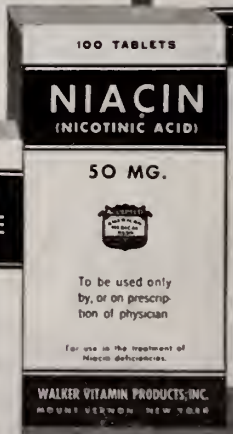














Furunculosis ... . second in the series: "FACIAL EXPRESSIONS OF SICKNESS"

From a practical standpoint, the use of penicillin orally should be limited to infections in which low doses of parenteral penicillin have proved adequate, for prophylaxis, and for the convalescent stages of such acute infections as furunculosis. Here, when the crisis is past and the fever receded, the administration of 100,000 units of penicillin orally at two or three hour intervals, day and night, for 48 hours is a tested safeguard against relapse. For such prophylaxis, tablets of calcium penicillin, 50,000 units each, are available in bottles of 12.

PENICILLIN TABLETS ORAL by Bristol
LABORATORIES INC.
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Refer your patients to

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There can be no middle course between the ethics of the medical profession and the temptations of the market place in the field of anatomical supports. Here the standards of the businessman must be elevated to the standards of the doctor because the customer of the businessman is the patient of the doctor. Anything else is "merchandising quackery." We at Camp have for many decades controlled our distribution throughout the recognized retail institutions which, like the doctor have earned the respect and confidence of their home communities. No appeal is used in our advertising approach to the consumer which fails to meet the precepts of the profession. We serve the physician and surgeon by living up to our chosen function of supplying scientific supports of the finest quality in full variety at prices based on intrinsic value. We try to insure the precise filling of prescriptions through the regular education and training of fitters. In cooperation with medical and educational public health authorities we play the role our resources permit in promoting better posture and body mechanics. That is our idea of the practical ethical standards which permit the businessman to solicit the recommendation of the doctor.

Camp Anatomical Supports have met the exacting test of the profession for four decades. Prescribed and recommended in many types for prenatal, postnatal, postoperative, pendulous abdomen, visceroptosis, nephroptosis, hernia, orthopedic and other conditions. If you do not have a copy of the Camp "Reference Book for Physicians and Surgeons", it will be sent upon request.

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S. H. CAMP & COMPANY • Jackson, Michigan • *World's Largest Manufacturers of Scientific Supports*
Offices in CHICAGO • NEW YORK • WINDSOR, ONTARIO • LONDON, ENGLAND

Mothers

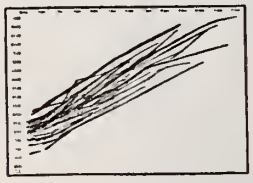
APPRECIATE THE SIMPLICITY OF PREPARING FEEDINGS



The preparation of Similac feedings requires only the addition of Similac powder to previously boiled, tepid water—in the proportions you prescribe. Mixing requires only 20 to 30 seconds. The simpler your directions to the mother, the less chance of error on her part. And simpler procedure in preparing feedings makes sanitation easier.

Physicians

LIKE THE UNIFORM RESULTS



Similac is simple to prepare . . . Modern . . . Ethical. It gives uniformly good results.



ACCEPTED AMERICAN MEDICAL ASSN Council on Foods and Nutrition

A powdered, modified milk product, especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat has been removed and to which has been added lactose, cocoanut oil, cocoa butter, corn oil, and olive oil. Each quart of normal dilution Similac contains approximately 400 U.S.P. units of Vitamin D and 2500 U.S.P. units of Vitamin A as a result of the addition of fish liver oil concentrate.

SIMILAC

Similar to breast milk

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EFFECTIVES . . .
but not cure-alls

Modern therapeutics support the premise that no single medication will successfully combat all ear conditions. For that reason . . . DOHO, specialists in the development of effective ear medications . . . offer

Auralgan

IN ACUTE OTITIS MEDIA

When pain, fever, edema, leucocytosis, sense of fullness and impaired hearing are present—AURALGAN by its potent decongestant, dehydrating and analgesic action provides effective relief of pain and inflammation.

O-TOS-MO-SAN

IN CHRONIC SUPPURATIVE OTITIS MEDIA

O-TOS-MO-SAN provides a new Sulfa combination of Sulfathiazole and Urea in Auralgan Glycerol (DOHO) base, completely water-free and having the highest specific gravity obtainable—scientifically developed.

O-TOS-MO-SAN exerts a powerful solvent action on protein matter . . . liquefies and dissolves exuberant granulation tissue . . . cleanses and deodorizes the site of infection . . . and tends to exhilarate normal tissue healing in the effective control of chronic suppurative Otitis Media. Excellent results have also been obtained in furunculosis of the external ear canal.

NOTE:

Where there is an intact ear drum, neither Sulfonamides nor Urea are effective . . . and under these conditions AURALGAN is indicated.

WARNING!

The indiscriminate use of the Sulfonamides should be avoided—so that infectious organisms do not become "sulfa-fast" or patients "sensitive" to Sulfa.

Write for Literature and Samples

THE DOHO CHEMICAL CORPORATION

New York 13, N. Y. · Montreal · London

Peptic Ulcer

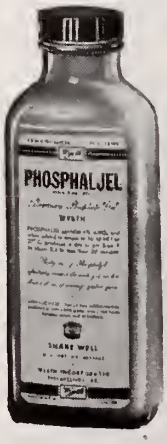
Stubborn cases call for PHOSPHALJEL

Phosphaljel is unexcelled in the treatment of marginal ulcer. It provides quick relief from pain . . . lays a protective coating over the inflamed mucosa . . . *safely* buffers gastric acidity with no danger of alkalosis or "acid rebound." Phosphaljel permits a liberal bland diet—patients are more contented during treatment, gain strength and weight more quickly.

Phosphaljel provides excellent prophylaxis against seasonal recurrences, as well as protection against marginal ulcer following surgery. It is highly valuable in cases complicated by diarrhea, pancreatic insufficiency or phosphorus deficiency, and is well adapted for continuous buffering by intragastric drip.

* * *

A new Wyeth motion picture, in full color, entitled "Intragastric Drip Therapy for Peptic Ulcer," illustrating the use and advantages of the intragastric drip apparatus is now available for showing before medical groups. Request a showing for your medical society. Address Professional Service Department.



PHOSPHALJEL®

ALUMINUM PHOSPHATE GEL

ACCEPTED AMERICAN MEDICAL ASSN

Wyeth®

® Reg. U. S. Pat. Off.

WYETH INCORPORATED • PHILADELPHIA 3, PA.

CLAIMS

VS.

DIFFERENCES

WHAT value have claims of superiority unless there is a difference in formula or process to justify such claims?

Take cigarettes for example.

PHILIP MORRIS Cigarettes are *made* differently. In the clinic as well as in the laboratory, the *advantages* of PHILIP MORRIS have been repeatedly observed, repeatedly reported by *recognized authorities* in leading medical journals. Yes, PHILIP MORRIS *claims* superiority . . . *and that superiority has been proved.**

May we suggest that your patients suffering from irritation of the nose and throat due to smoking change to PHILIP MORRIS—*the one cigarette proved definitely less irritating.*

PHILIP MORRIS

PHILIP MORRIS & CO., LTD., INC.,
119 FIFTH AVENUE, N. Y.

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

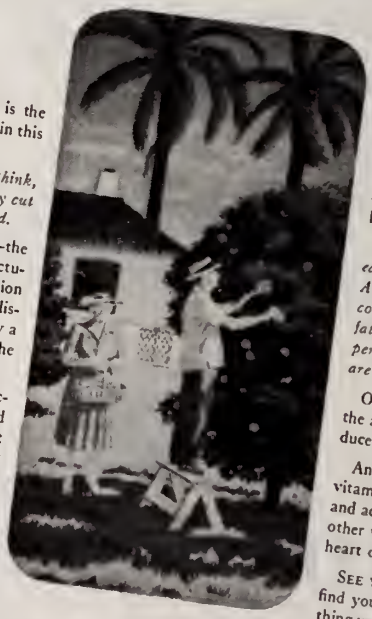
TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

The advice is always "SEE YOUR DOCTOR"

For over 18 years, Parke, Davis & Company has conducted an educational advertising campaign in behalf of the medical profession — teaching the importance of prompt and proper medical care. Now appearing in color in LIFE and other leading magazines, these "See your doctor" messages reach an audience of *more than 23 million people.*

Some things you should know about **heart disease**

No. 202 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



IT IS true that heart disease is the greatest single cause of death in this country.

But it is not true, as many people think, that heart disease must automatically cut short your life or make you an invalid.

A common type of heart disease—the so-called "functional" type—is not actually heart disease at all. It is the reflection of some other, usually correctable, disturbance in the body. It is often merely a temporary condition. It does not alter the heart itself, nor does it shorten life.

Even "organic" heart disease, which actually changes the heart's structure, need not be a serious disability. The handicap it imposes on a normal life will vary widely —with the nature of the disease and the individual case.

Symptoms are no indication of the seriousness of a heart condition.

Two men may have identical symptoms. One man's heart condition may dictate a careful limitation of his activities. The other man may be able to live a normal life span with only slight restrictions on his way of living.

Medical science during the past few years has made great progress in understanding the nature of heart disease, and in developing new methods of prevention and treatment.

Doctors today, by proper treatment of rheumatic fever in children, prevent many future cases of heart disease. And today doctors can also *cure* some cases of heart disease which would have been considered hopeless a few years ago.

There is, for instance, a kind of heart disease known as subacute bacterial endocarditis. A few years ago doctors were helpless in combatting what was practically always a fatal infection. But now, through the use of penicillin, an increasing number of cases are being successfully treated.

Other drugs help your doctor to regulate the action of an irregular heart and to reduce the strains that are put upon it.

And his modern knowledge of diet and vitamins, and the prevention of anemia and acute respiratory infections gives him other weapons to use against progressive heart disease.

SEE YOUR DOCTOR. If at any time you find yourself wondering: "Is there something wrong with my heart?" . . . see your doctor at once.

If he finds your heart in good condition, an enormous load will be lifted from your mind. And if something should be wrong, your doctor's prompt diagnosis and treatment give you the best chance for living a long and normal life.

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Makers of medicines prescribed by physicians

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Research and Manufacturing Laboratories, Detroit 32, Michigan



PLANNING · NOT LUCK

Neo-Iopax

Planning—not luck—is responsible for the pure, crystal-clear solution of NEO-IOPAX for urography. Every precaution known for obtaining a sterile fluid, completely free from foreign particles, is taken with this contrast medium during its production. And when NEO-IOPAX is ampuled it must pass before a corps of specially trained inspectors whose sole task is to detect and reject any solution containing the least visible trace of extraneous matter.

A final inspection by the physician himself before intravenous or retrograde injection is invited by the water-clear glass ampule in which NEO-IOPAX is dispensed.

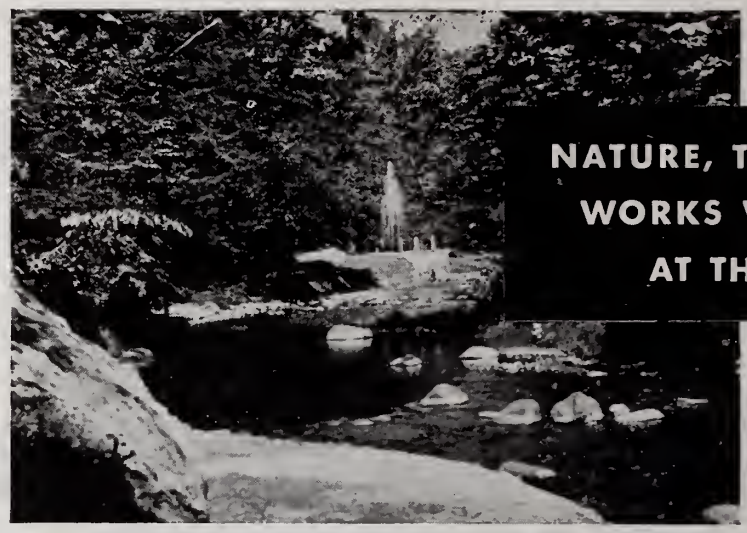
NEO-IOPAX, disodium N-methyl-3.5-diiodo-cholidamate. is supplied as a stable, crystal-clear solution in 50 and 75 per cent concentrations.

Trade-Mark NEO-IOPAX—Reg. U. S. Pat. Off.

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IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL



NATURE, THE HEALER, WORKS WONDERS AT THE SPA



The superb man-made facilities at the Saratoga Spa are placed in a setting of great natural beauty. In this serene environment a sick person is ideally prepared for the full benefit of medical care.

Here your patient is relaxed in both mind and body, so that the therapeutic values of the Spa's naturally carbonated mineral waters are enabled to exert their maximum efficacy.

Your patient suffering from such conditions as cardiac, vascular or rheumatic disorders receives the benefit of the Spa's restorative powers under a regimen of treatment which you yourself recommend.

Well trained physicians are available in Saratoga Springs for consultation with your patient on the details of the program.

With your patient at the Spa, you find needed relief from postwar strain in the knowledge that your directions for his continuing care will be faithfully carried out.

THE SARATOGA SPA

"PHYSICIAN, GIVE HEED TO THINE OWN HEALTH"

Many physicians have recently come to the Spa for the same kind of treatments that helped their patients here. After a restorative "cure" at the Spa, you, too, would return to your practice refreshed—revitalized—ready for the busy days that still lie ahead.

Listed by the Committee on American Health Resorts of the American Medical Association.

THE EMPIRE STATE'S CONTRIBUTION TO THE MEDICAL PROFESSION

For professional publications of the Spa, and physician's sample carton of the bottled waters, with their analyses, please write W. S. McClellan, M. D., Medical Director, Saratoga Spa, 159 Saratoga Springs, N. Y.

PRIVINE

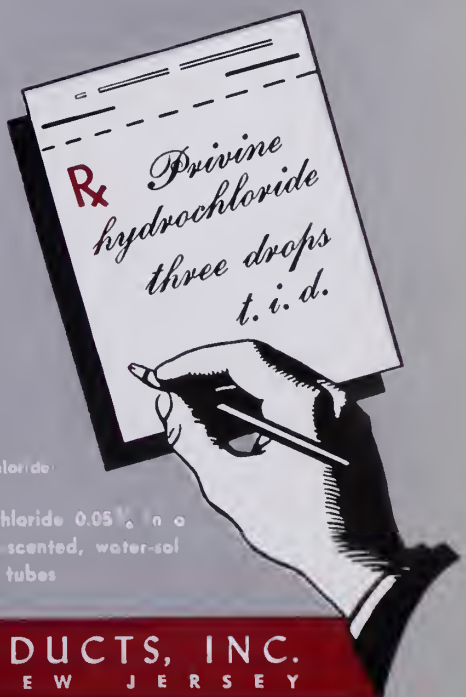
IN ACUTE RHINITIS



ACCEPTED
AMERICAN MEDICAL ASSN.
Council on Pharmacy and Chemistry

RELIEF SO LONG WITH SO LITTLE

Even in minute doses the administration of this powerful vasoconstrictor results in prompt and prolonged relief from nasal congestion. Three drops of Privine Hydrochloride in each nostril t.i.d. is usually sufficient dosage. The infrequency of side effects allows Privine to be used before retiring with little likelihood of interfering with normal sleep. The new Privine Jelly is particularly useful between office visits.



Trade Mark Reg. U.S. Pat. Off. and Canada (Privine Hydrochloride) — brand of naphazoline hydrochloride

CIBA

Solutions: 0.1% for adults only, 0.05% for children and adults. In 1 ounce bottles with dropper.

Jelly. Privine Hydrochloride 0.05%. In a blond, buffered, pine-scented, water-soluble base. In 20-gram tubes.

CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT NEW JERSEY

CIBA

For complete literature, write the Ciba Professional Service Department. Special questions involving search of the literature or other inquiries of this nature will be given particular attention. Use this service as an aid to your practice.

TRICHOMONAD ERADICATION

In Trichomonos leukorrheo the use of Vioform Inserts ond Insufflote quickly erodicotes the orgonism ond restores the normol pH of the vogino. Besides Vioform—brond of iodochlorhydroxyquinoline, these preporotions contoin loctic ond boric ocids to restore normol pH.

PLEASANT-TASTING IODIDE

Potients will be groteful for your prescription of pleosont-tosting Lipoiodine—brond of iodobrossid. Contoins 41% of orgonic iodine, ond moy be used to reploce olkoline iodides. No gostric irritotion; liberoted slowly, with lengthened, uniform effect.

RAPID DIGITALIZATION

Digifolin—brond of digitolis glycosides, contoins the octive components of digitolis leoves, ond is free of inert ond undesiroble ingredients such os soponins. One "cot unit" of Digifolin equols 1 U.S.P. XII digitolis unit.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

Lipoiodine, Vioform, Digifolin—Trade Marks Reg. U. S. Pat. Off. and Canada.

Presented herewith are three products of Ciba research, each accepted for New and Non-Official Remedies by the Council on Pharmacy and Chemistry of the American Medical Association.

VIOFORM



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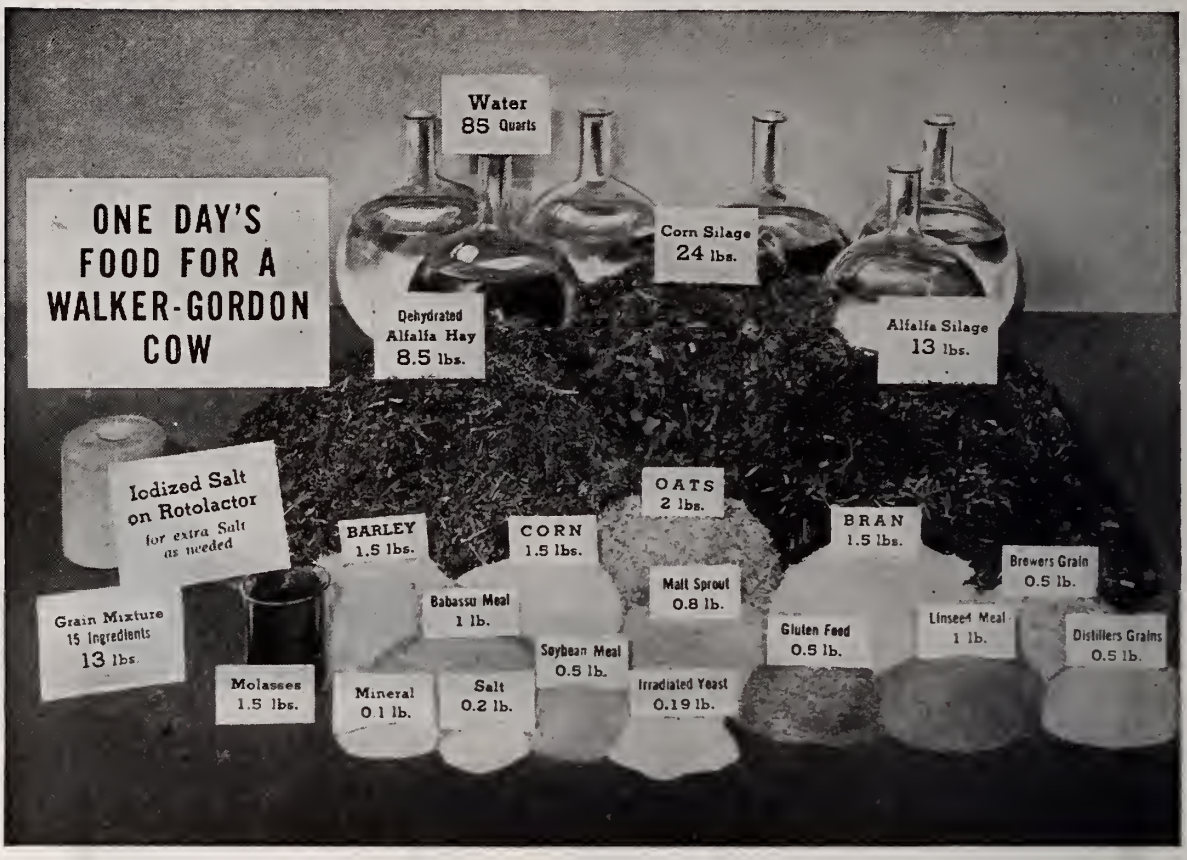
The sick or injured patient is almost simultaneously subjected to two traumas—the basic pathologic process and tissue malnutrition—for malnutrition almost always begins "as soon as injury or disease occurs."[1] Recognition of the vitamin depleting role of dietary restrictions, increased metabolism, glucose infusions, and impairment of absorption, has brought with it the realization that vitamins must be administered in therapeutic—not maintenance—dosages when multiple deficiencies complicate disease. Upjohn provides a full range of maintenance and therapeutic vitamin preparations for oral and parenteral administration.

1. J.A.M.A. (April 22) 1944

Upjohn
KALAMAZOO 99, MICHIGAN

FINE PHARMACEUTICALS SINCE 1886

UPJOHN VITAMINS



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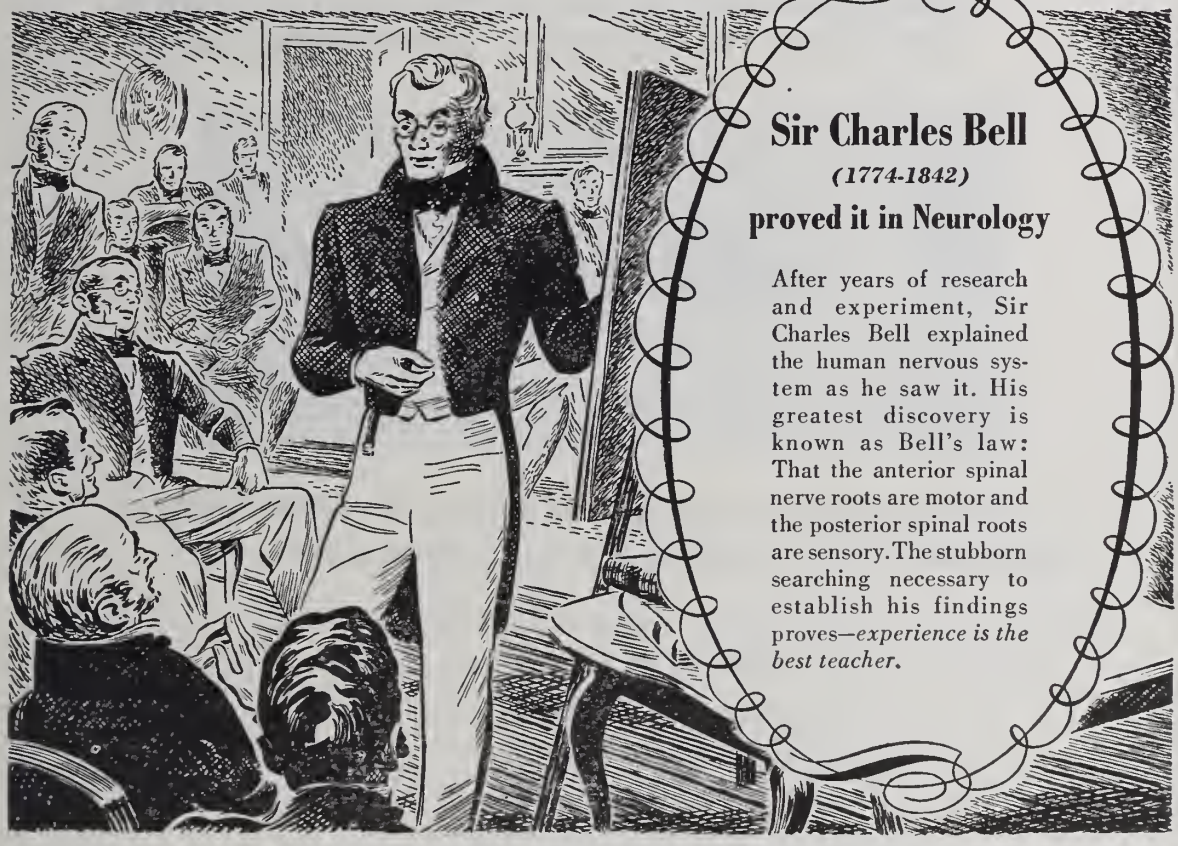
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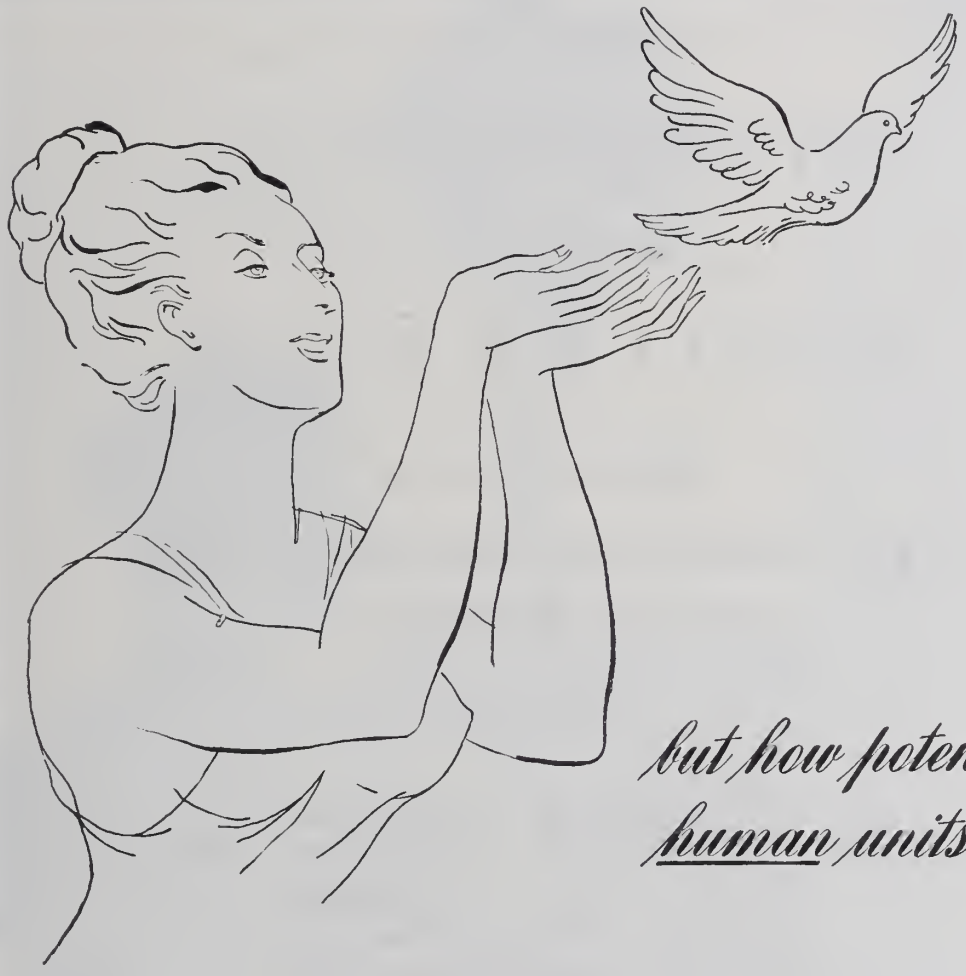
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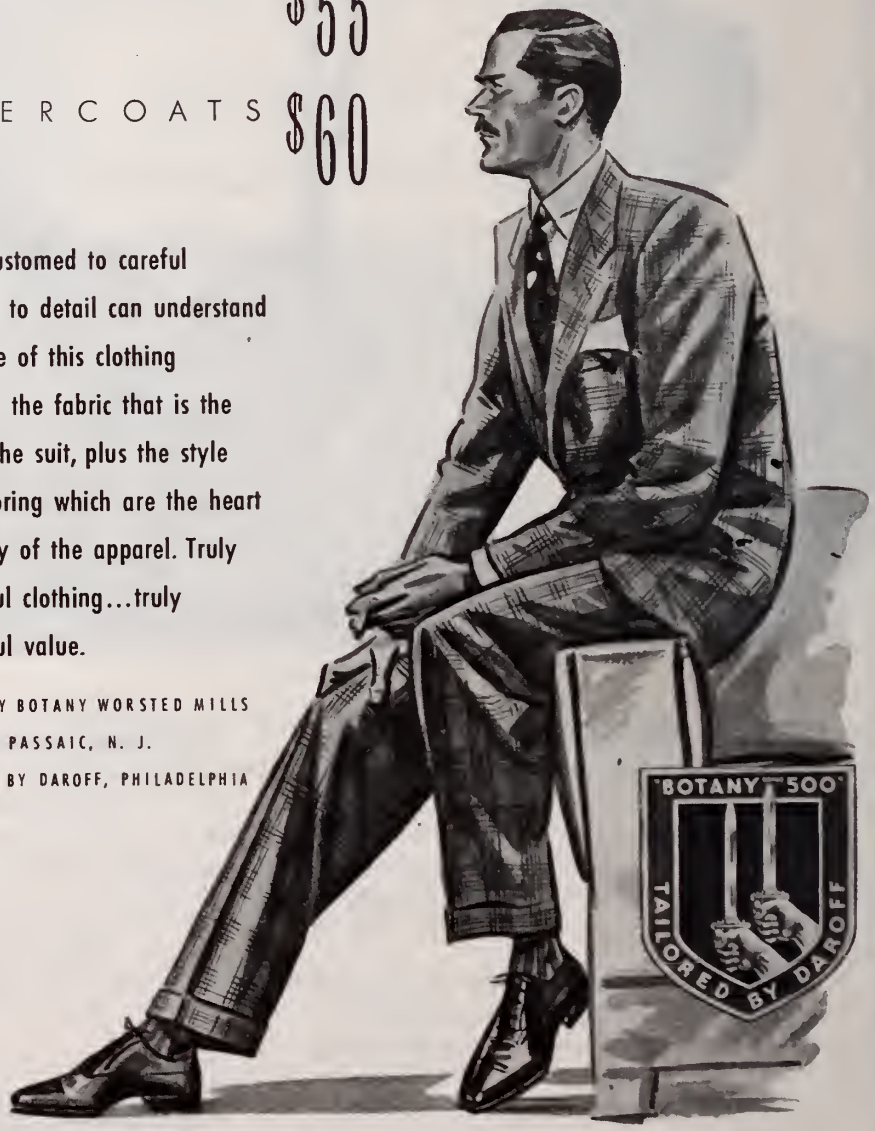
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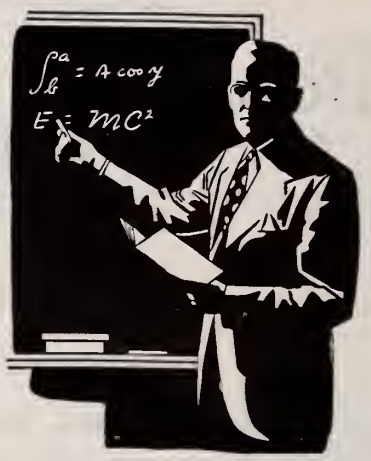
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*Kamman, G. R.: Fatigue as a Symptom in Depressed Patients, Journal-Lancet 65:238 (July) 1945.

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THE LAST INDIVIDUALIST

Perhaps when the last chapter is written, it will appear that the doctor of medicine resisted longer than any one else the pressure for identification with a group. The grocer goes to work for the chain store, the attorney for the huge law firm. The "personal" journalist of the small town becomes a copy editor for a chain of newspapers. The columnist is only a single item in a stable of syndicated writers. The once temperamental actor accommodates his schedule to the rules of Actor's Equity and before long we may expect an artist's "Authority" to regulate even that individualistic activity.

But, you say, we doctors have our organizations too. We conform to the rules and ethics of the medical society and to the requirements of a medical practice act. Yes, we conform. But only within the broad limits laid down by law and canon. And those limits are generous indeed. Let a medical society issue a formulary and urge all doctors to limit their prescriptions to its contents. There will be mutterings of "No one is going to tell me what to prescribe" and the formulary will gather dust on a corner of the desk. A century ago, The Medical Society of New Jersey adopted a fee schedule and tried to discipline members who charged more or charged less. The doctors refused to conform; and refused to be disciplined. A medical society can mould its members only to the extent that they voluntarily accept the moulding. Let any society go one iota beyond this, and its recommendations are ignored.

Outsiders who attend medical society conferences wonder at the chairman's inability to "control" even the devoted officials of his own society. Lay executives find it hard to understand why medical societies cannot discipline their members as effectively as, say, labor unions and political parties can discipline theirs.

Individualism may be a virtue or a

handicap. That's a question for the philosopher. But the unwillingness—or inability—of doctors to accept strong organizational leadership means that medical societies will never have the monolithic effectiveness of better disciplined organizations. A truly efficient organization, one that acts swiftly and with complete unity, needs dynamic leadership, with decisions crisply made by those selected to make them, and with power to commit the resources of the organization to the implementing of those decisions. In a medical society, however, there can be no privates or corporals or even sergeants. In medical organization, as in the army, we are all officers. We're free-born, fully licensed, responsible only to ourselves. That's the way we want it.

If some day the entire medical profession finds itself working as employees of hospitals, of the government, or of health insurance companies, we can punch the clock with a warm inward feeling, that anyway, we remained rugged individualists to the end.

QUESTIONNAIRES

Indicted by many physicians as a thief of time, the questionnaire still keeps coming across the desk. Doctors, on the whole, are not as responsive to questionnaires as the compilers would wish. Even the stamped self-addressed return envelope proves to have little bait value. The practitioner usually pulls the form half out of the envelope, sees the array of little boxes (mark with a check) and the numerous "yes" and "no" lines, heaves a groan and tosses the questionnaire into the waste basket.

In the long run, however, this cavalier attitude towards questionnaires may hurt the doctor more than the statistician. Analysts will interpret the replies whether your return is there or not. If too many physicians fail to send in the questionnaire, the results will be skewed, since they will omit the experience and opinions of the large group of practitioners who have ignored the form. If the questionnaire results in action, the action will obviously not be in the direction desired by the unresponsive group.

Actually, modern methods of questionnaire compilation have removed most of the time-waste and the pain formerly associated with checking a long form. A contemporary questionnaire is neither complicated nor time-taking. It is especially vital for practitioners to cooperate in studies being conducted by their own organizations. There may be some excuse for not answering a set of queries about what brand of cigarets you favor; there is no excuse for ignoring a questionnaire submitted by a reputable medical organization. For instance, the recent child health survey of the American Academy of Pediatrics will pool the experiences of hundreds of thousands of doctors. Had the study been sabotaged by default, this unresponsiveness would have been construed as the practitioner's unwillingness to cooperate in a public health project. It would have given the enemies of organized medicine a chance to say that doctors were not socially-minded or that they were not to be trusted with administrative authority. And incidentally, it would have given a spurious picture of the state of child care in the country.

Equally cogent reasons impel physician-veterans to answer the questionnaire about their work in the armed forces. And this month, many practitioners will receive a "questionnaire on care of civil-

ians during World War II. This provides an opportunity for those who were responsible for medical care on the home front to indicate what changes should be made in the mobilization of civilian resources during the next emergency. Doctors often complain that they are not consulted in planning medical care projects. Here, however, is a mechanism for consulting them. The physician who fails to return this questionnaire can hardly complain of "regimentation" or organizational "dictatorship" in the future, if he passes up this chance to have his say.

We are entering an era of vast potential change in the face of medical practice. We have a chance to express our opinions and record our experiences through the questionnaires that have been and will be sent out. There is no other way of polling an entire professional community. It will have to be done by appraising responses to questionnaires. The alert practitioner will not deliberately disfranchise himself.

BUSINESS ADMINISTRATION AND PROFESSIONAL SOCIETIES

Time was when a medical society focussed most of its activities on strictly professional and scientific programs. Even "business meetings" were concerned largely with such problems as standards, licensure, hospital staff policies and the like. During the past decade however, medical organizations have developed more and more "business" functions. Voluntary health insurance, for instance, contracts with the Veterans Administration, journal and bulletin advertising, liaison with hospital care plans, group malpractice insurance, analysis of legislative proposals, increasing public relations activities, projects for the care of the indigent, etc. It is no longer possible to think of a medical society as a "purely scientific and educational" organization, even though this is still the *primary* orientation of the society.

With the growing complexity of these "business" functions has come the need for business-like methods. Constitutions and by-laws must conform to legal requirements, if legal contracts are to be made. Bookkeeping methods must meet standards of good accountancy practice if books are to be audited. Public relations officials must compete with commercial enterprises in seeking the public eye and the public ear.

To meet these needs, nearly all state societies now have fixed addresses, paid staffs, and full-time executive officers. More and more county societies have found that a central office and office staff are necessary to maintain their "business" functions. Indeed, any organization legally competent to enter into contracts must have a definite mailing address, and the old custom of moving the medical society office with the person of the secretary will no longer do.

The phrase may grate harshly, but the fact remains that today organized medicine is really "in business". And to survive under those circumstances, requires business-like methods.

ORIGINAL ARTICLES

THE PHYSICIAN AND SOCIAL RESPONSIBILITIES

Edward W. Sprague, M.D., Newark, N. J.

We are living in a serious period—a time when it is difficult to discern the future trends of human relations. We see things very dimly. While society still has leaders with great awareness, many individuals have only an ostrich-like view of affairs. Some are in the inertia of deep slumber; others are smugly complacent. Tremendous forces in the social and economic world are in motion and may be gathering momentum toward a most disturbing and troublesome future unless guided aright. Our field of endeavor is particularly essential to society and is most vulnerable. Thus it behooves the physician to strive at an understanding of the true relation of medicine to the facts of present day life. This is a period of industrial civilization and the increasing complex social problems arise chiefly from that situation.

Certain world conditions of unsettlement are evident. Today a large area of Eastern Europe is under the influence of communism. Large sections of the people are drifting into radical socialism. Some of our southern neighbors are looking at fascism and other groups are poised in uncertainty. England is experimenting with nationalization of most of its social services and even now the British Medical Society is in a life and death struggle to preserve what little individualism in practice has been left since the socialization of medicine began. British physicians are deciding today whether they will or will not embrace the government plan of complete socialization. There is a strong feeling here and abroad that what takes place in England must soon follow in the United States. We must bear this idea in mind in order to cope with or prevent undesirable trends.

Understanding of the world about us is most difficult, but if we as physicians are to survive as an independent unit useful to society and to ourselves, we must try to recognize dangers at their onset and to learn why the movement to socialize medicine is being urged persistently by so many groups. Real dangers are ahead. We have seen and we are facing drifts toward statism. During the past decade the drifts have been accelerated. We have seen many earnest trials and many failures of schemes intended to relieve certain unfortunate situations in which society becomes involved now and then. One fundamental idea of sound economics is that no scheme should be experimented with which would be bad for society in the long run. This principle, after all, is just good common sense and that is, in reality, what good economics is.

During the depression of the thirties the great emotional improvisations of the federal government failed to stabilize our economy and also failed to find or to relieve the underlying causes of our economic difficulties in spite of vast public expenditures and a debt of forty billion dollars. Since then, the war with its frightful waste of life and material leaves us with even greater problems to face and the recent majority change in Congress is no guarantee of their solution. The exhausting effects of our great national debt will be upon us for years. Believing the fallacious pronouncements of some liberal economists, such as "the beneficence of public debt", or, "the debt is harmless as we owe it to ourselves", will lead only to trouble or despair. When needs are lessening, business may decline for a time and unemployment appear with its long chain of untoward effects. Probably no plan as yet devised can do little more than shorten the period of readjustment. When that time comes,, the well tried ways of work, thrift, avoidance of debt and assistance to the less fortunate will carry us through.

Depressions we will have and during such days of stress schemes will again spring up all along the horizon. The physician should be a

student of economics and must ever be watchful. We must realize that great forces are crusading honestly for socialized medicine. They believe in it. Just now they may seem to be less evident, lulling us into inactivity and a false sense of security, but look around today and see how near the governor of California came to putting socialization of medicine on the legislative books. Several of our presidential candidates lean to state medicine in some form. Recall President Truman's health program. Many leaders of organized labor have great hopes of providing compulsory medical care on a national scope. We may have one or two years of breathing space before more powerful moves are made for regimentation. This is our time of preparation for leadership.

The general and economic perils are of the first magnitude but there is an equally important danger within ourselves and our profession. Lack of awareness or interest on the part of the individual physician and indifference to the problems of the distribution of medical care on the part of organized medicine are most destructive. Never has the physician failed to respond to the call for service. However, now he has to meet the fact that certain large areas do not have available physicians and the same areas often do not have adequate clinic or hospital facilities. Their health standards are low. This condition is our utmost concern. We cannot safely be complacent medical isolationists. We must assume our social responsibilities and strive to solve the problems of medical care. The problems are many and nation wide, behooving the physician to think clearly and not be bewildered or baffled by their vastness. If he will be realistic and reduce his thinking to terms of the unit of society—the family—solution of the problem will be more easily arrived at. Adam Smith said in *The Wealth of Nations* 175 years ago,—"What is prudence in the conduct of every private family can scarce be folly in that of a great kingdom". That adage is valid today.

This nation was founded by men of great vision. They realized that mankind was motivated by two strong forces, self interest and altruism. They recognized the fact that the forces of self interest predominated and that while man is as he is, he will progress more surely in an atmosphere of freedom; that the free enterprise system will encourage development of talents to their utmost; that the lack of predominance of altruism necessitates some controls and directions on the part of the government. America has gone forward and people in every walk of life have realized their highest possibilities under this democratic process. This is a demonstrated fact of the American way of life. Therefore, we must insist that this same favorable state of social relations shall prevail in the practice of medicine. Without freedom the highest spiritual values of medicine will be lost to society.

The discoveries and accomplishments of medical science are life saving and are increasing in an almost geometric ratio and these facts appeal to the desire and imagination of all. Elton Mayo says, "When we talk of social problems, we are apt to forget that every social problem is ultimately the individual". We must not blame the public for feeling that the benefits of medical care should be made available and attainable by everyone. We believe wholeheartedly in this idea; and believe that we know best how to bring such conditions about. We can understand why the uninformed public believes that the powerful federal government should provide full covereage service and that medical care should be socialized. However, we know that socialization is an idea which fails to reckon with human behavior and that the best type of medical care cannot be achieved in this manner.

To many well intentioned social planners and government officials it would seem that medical care is a commodity and that the physician is a public utility which should function perfectly as a machine in any environment. This viewpoint overlooks the fundamental fact that the application of the new and old discoveries still depends on the function of the individual physcian in the individual case. Essentially, all rests on the intellectual process of diagnosis by the physician. Here is the sole key to the successful application of medical science to the patient. The whole structure of medical practice depends on the physician. The public must be told and retold this fact.

The two great social institutions in this world are family and religion and they have survived without state control or compulsion. The state is not an inspired omnipotent body. It is merely a group of individuals whose purpose is to accomplish understanding and cooperation in undertakings to protect life, liberty and the pursuit of happiness.

In family relations the state should not insinuate itself so as to direct and control them. Surely this applies to the intimate family relationships in the practice of medicine by physicians.

At this point we might restate the dependable thesis which must be fundamental in our thinking and action: (1) that the individual physician and the medical organizations do aim and strive to provide the best type of medical care for the people at a price level which they can afford; (2) the profession believes that the type of care which preserves the unhampered patient-physician relationship, must be based on free choice of patient and physician freely operating in competition among physicians in the pattern of private enterprise. This care must be entirely free from the dangerous element of compulsion from any source and without crippling and stifling control from government bureaus. Maintenance of this type of medical care will yield continued improvement and benefit to the people.

Any comprehensive voluntary effort to aid in the solution of the problem of medical care and its distribution must include plans on a national scope and all the lesser government levels. The key to the satisfactory operation of any plan must be the individual state. If, for example, adequate medical care in every phase is provided in New Jersey on a voluntary basis, there will be no need for its participation in any federally controlled medical scheme; and as New Jersey leads, other states may follow.

Today for the first time, the American Medical Association has abandoned its negative stand. A lay organization was employed to review its activities. The Rich report has made the officers and delegates realize their responsibilities and opportunities. Leadership from on high has been tardy. Now we may expect great things. A study of the reports of the recent meeting of the House of Delegates impresses one with the great multitude of activities and interests which may be important and useful in the main, yet their very volume is confusing and dissipating of the central idea of preservation of our way of life.

So it is time we came forth with a basic theme that all schemes of governmental socialization of medicine are needless and harmful and will fail of accomplishment and that we offer an idea which if put into operation, will bring about the ideal in the distribution of medical care. We believe that a National Medical Care Foundation should be formed with broad scope and vision, and that coordinating state medical care committees should be formed in each state to work in conjunction with state and local governments and the state and county medical and allied societies.

The idea of a National Medical Care Foundation should be initiated and promulgated at once by The Medical Society of New Jersey, either through the American Medical Association or by direct conference with our senators or representatives in Congress.

For purposes of understanding, this Plan may be divided into three sections:

SECTION 1

The American Medical Association should lead and cooperate actively with allied professions, national health services, all groups interested in medical care, and representatives from Congress to form The National Medical Care Foundation which would, in addition to other designated functions:

A. Gradually become the only governmental bureau and center of all national medical care assistance and information.

B. Accumulate nation wide information as to facilities or lack of facilities for medical services including personnel, hospitals, clinics, et cetera.

C. Determine the degree of needs in an overburdened state and recommend sufficient subsidy by direct grants or grants in aid or matching of state funds.

D. Carry on an active campaign as to what constitutes good medical care, urging the people to abandon self-medication, and to use available facilities of scientific medicine, to stop misinformation over press and air.

E. Encourage coverage by voluntary hospital and medical plans.

F. Correlate the activities of state plans and the National Foundation—providing a central source of information and assistance.

G. Set up standards of the clinical values of new drugs and chemicals.

H. Cooperate with public health services.

I. Promote research, disease prevention and health preservation.

SECTION 2

The Medical Society of New Jersey should organize a New Jersey Committee for Medical Care with the cooperation of allied professions, state and local health departments, the Department of Institutions and Agencies and other interested agencies with representatives from the senate and assembly appointed by the Governor.

The New Jersey State Committee for Medical Care would be the effective operating unit on a state-wide basis with a broad scope of functions similar to the National Foundation but not under national authority.

The recently formed New Jersey Health Congress is a long step in the right direction and might well encompass the objectives outlined in the state committee functions and add many others. This present health congress would be better understood by changing its name to The New Jersey State Committee for Medical Care.

The State Committee for Medical Care would have the following functions in addition to others which might be developed:

A. Securing necessary authority from the state government.

B. Evaluation of present facilities including a census and location of physicians, dentists, nurses, hospitals, diagnostic clinics and health departments.

C. Determination of the needs in all sections of the state and recommendation that state funds be expended for implementation when local means are insufficient to meet the requirements; thereafter to appeal for federal aid if the state is unable to provide the necessary subsidy.

D. Recommend that the indigent and medically indigent be cared for on a free choice basis on a fee for call arrangement between the local physician and local government, subsidized by the local government. Eligibility to be determined by someone other than the physician.

E. Promote the development of voluntary hospital, medical, surgical and dental plans.

F. Cooperate with and promote all health maintenance measures.

SECTION 3

Special participation of The Medical Society of New Jersey would include:

A. Pursuing the initiation of The National Medical Care Foundation idea to its formation,

B. An effort to make each physician realize his social responsibilities in this endeavor.

C. A state public relations program to:

1. Educate the public as to the best type of medical care and show where it is available and how it is attainable.
2. Show our leadership in cooperation with the above outlined State Committee for Medical Care.
3. Promote the Medical Service Administration and its plans.
4. Reiterate that the profession desires to furnish medical care at a price which the patient can afford. (From time immemorial the physician has been a tower of comfort and refuge for the unfortunate sick. He has served them gladly without pay but often the burden is too great and should not be borne by the physician alone). The state and its subdivisions are becoming aware of their responsibilities and more and more subsidy is being provided for the indigent and medically indigent. Here the profession and the state have a joint responsibility and the physician should continue to participate by accepting rates below his usual fee for the indigent and medically indigent.

This whole plan involves leadership on the part of organized medicine and it means cooperation of physicians with allied groups and existing health and allied agencies with government at all levels.

Consummation of the program depends on the efforts and wisdom of all physicians. Awareness, understanding, sacrifice and action on the part of the individual physician will be required to satisfy the citizens of New Jersey that the profession is worthy of their continued trust in our leadership in matters pertaining to medical care and its distribution.

Must we experience state medicine to know its shortcomings — its unfortunate circumstances and its failures to give the public the best type of medical care? This would be an irreversible condition which we would dismally discover too late and the lost public would be slow to recognize any of the hard-to-find roads back to the former status. Can we not stop the movement now? Can we not

see from the experience in other lands how far the scheme falls short of providing its hoped for goals? Let us not impeach the intentions of those who believe that state medicine is the answer to man's medical problem. Can we not analyze the schemes of planners—social reformers and others, and separate the good from the bad ideas? Not all movements are beneficial to society. Remember the monstrous mistake of the prohibition law. See the far reaching disservice to society that anti-vivisection laws would render. These acts were planned by people with honest intentions.

It will be a fatal mistake for physicians to take the defeatist attitude that regimentation is surely coming—or that it is a dead issue and can be put out of mind. Keep the issue before us and reason about it. We must oppose all systems of federal compulsory socialization of medicine under any guise whatever. It is our duty to show the people that they will not benefit by such plans. They are all dangerous to the best medical care no matter how innocent they may appear at the onset. They run contrary to the democratic system under which we live.

Forming The National Medical Care Foundation and the state committees for medical care, creates the beginning of a solution of the problem by lifting it out of politics and placing it on a foundation of knowledge and honest desire to meet the needs in the distribution of medical care.

Full realization of our social responsibilities with enlightened self interest and continued self discipline will enable us to lead society aright in its efforts to make the best type of medical care available and attainable by all.

86 Washington Street

MEDICAL-SURGICAL PLAN OF NEW JERSEY

As of January 31, 1947, 93,442 persons were enrolled in the Plan.

The Plan aims at all times to operate within the framework of our present methods of practice, and according to the expressed policies, traditions and ethics of the profession.

Consistent with this the Board of Trustees of the Plan believes that the patient is entitled to know the cost of a physician's service at the time the service is requested.

The Board suggests that when a patient, not entitled to full service benefits in accordance with the schedule of benefits of the Plan, requests the services of a Participating Physician, that the patient and physician agree at this time on the amount of any additional payment to be made

A pamphlet of information has recently been mailed to every physician in New Jersey. Additional information may be obtained by addressing the Plan at 31 Clinton Street, Newark (2), New Jersey. Phone MItchell 2-0675.

PHILADELPHIA POSTGRADUATE INSTITUTE

The Eleventh Postgraduate Institute will be held on the Roof Garden of the Bellevue-Stratford Hotel in Philadelphia, April 15 to 18, 1947. Theme of the meeting will be "Symposia on Medical Progress".

Among the subjects to be covered are thyroid problems, diabetes, vitamins, hormones, intestinal disorders, kidney pathology, peripheral vascular diseases, antibiotics, hypertension, diseases of the lung, neuropsychiatry, stomach and duodenum, allergy, skin disorders, and otolaryngologic diseases. There will also be two evening meetings at the Philadelphia County Medical Society building on the subjects of childhood and infancy disorders, and obstetric and gynecologic problems.

Registration fee for the entire course is $5. for nonmembers of the Society. Out-of-town physicians planning to attend are urged to make hotel reservations immediately.

For further information write to Dr. Gilson Colby Engel, 301 South 21st Street, Philadelphia 3, Pa.

TREATMENT OF MENINGOCOCCIC MENINGITIS *

EMILIE V. RUNDLETT, M.D., F.A.C.P., and
CARROLL MOTON LEEVY, M.D., Medical Center, Jersey City, N. J.

The control of an infectious disease is dependent first upon prevention; secondly upon early recognition and proper treatment of the disease. The epidemiology, prophylaxis and diagnostic criteria of meningococcic meningitis are well established. Oral sulfadiazine effectively lowers the meningococcal carrier rate during an epidemic and reduces incidence of the disease without producing serious toxic drug reactions.

In treatment, the place of serum, sulfonamides and penicillin in the individual case has not been delineated. Sulfonamides have replaced serotherapy, but some feel that serum is indicated in the very ill patient as a supplement. Penicillin has been found a potent antimeningococcal agent *in vitro* and has been employed with varying results clinically. The purpose of this communication is to review our experiences with the available drugs.

Between 1935 and 1946, one hundred ninety-four patients were treated in the Jersey City Medical Center for meningococcic meningitis (Table I). In this series, 13 patients were babies less than one year old; 59 between one and ten; 51 between ten and twenty; 47 between twenty and forty; 16 between forty and fifty; and seven over fifty years old. In thirteen patients, purpura was a cardinal manifestation. Not included are patients with septicemia and the Waterhouse Friderichsen Syndrome when meningeal invasion was not demonstrated.

INCIDENCE BY YEARS

1935-36	13
1936-37	12
1937-38	3
1938-39	4
1939-40	4
1940-41	10
1941-42	10
1942-43	26
1943-44	59
1944-45	35
1945-46	18

TABLE I

Thirty patients seen before 1940 were treated with antimeningococcal serum. Three received serum and sulfonamides, the latter because of a lack of response to serotherapy. One hundred forty-four patients were treated with sulfonamides—two with prontosil, six with sulfapyridine, one with sulfonilamide, and one hundred thirty-five with sulfadiazine. Two patients received penicillin alone; and fifteen patients received combined sulfadiazine and penicillin.

Serum was administered systemically and intrathecally. Approximately 25 per cent of the patients had serum reactions consisting of nausea, vomiting, skin eruptions and prolongation of febrile course. No deaths or anaphalactoid reactions were noted.

Sulfadiazine was the sulfonamide of choice. In children we used one grain per pound of body weight (125 milligrams of the drug per kilogram of body weight). In adults, dose was four to six Grams (sixty to ninety grains) initially, followed by one to two Grams (fifteen to thirty grains) every four hours dependent upon blood levels and clinical response. Booster doses were used when therapeutic levels of sulfadiazine were too low, a blood level between 10 and 13 milligrams per cent and a spinal fluid level of 7 to 10 milligrams per cent being maintained. Alkalinization was maintained with sodium bicarbonate by mouth. Eleven per cent of the group receiving sulfonamides had reactions, the bulk of which were incident to renal changes; one patient developed a marked leukopenia; one died of uremia. Nausea, vomiting, fever, and skin rash were other changes seen. Hematuria was not a reason for stopping sulfonamides but it indicated need for increased efforts to provide sufficient fluid and alkali to prevent further damage.

Penicillin was given both systemically and intrathecally. The systemic dose varied from 10,000 units every three hours to 40,000 units every two hours; the intrathecal dose varied from 10,000 units to 50,000 units daily. No specific reactions followed penicillin therapy.

* From the Contagious Disease Hospital, Jersey City Medical Center, Jersey City, N. J.

While sulfadiazine is able to cross the hematomeningeal walls with great facility (allowing oral and systemic administration of this preperation) penicillin penetrates the meningeal barrier too erratically to justify its use extrathecally alone in meningitis therapy.

RESULTS

Low spinal fluid sugar, unconsciousness, and extremes in age are all accompanied by poorer prognoses. A previous study in this clinic stressed the prognostic value of the spinal fluid sugar. In a recent survey of our experiences with bacterial meningitidies of all types, it was evident that irrespective of therapy or type of meningitis, age had a marked influence on mortality. (See Table II.) Since 1935, there have been no deaths in patients treated for meningococcal meningitis between 21 and 50 years of age. Over age 50, the mortality rose sharply to 57.1 per cent and was 15.3 per cent in children under one year of age. Coma or unconsciousness is a clinical reflection of gravity of a disease process and prognosis is poorer when coma is present.

EFFECT OF AGE ON MORTALITY IRRESPECTIVE OF THERAPY

	No. Treated	Died	Mortality Rate
Under 1	13	2	15.3 %
1-10	59	3	5.08%
11-20	52	3	5.7 %
21-40	47	0	0
41-50	16	0	0
Over 50	7	4	57.1 %

Table II

Of the thirty patients treated with serum, seven or 23.3 per cent died. An analysis of the deaths (Table III) shows that one patient was two months of age, five had no spinal fluid sugar, six were unconscious. Two deaths occurred in the group receiving serum and sulfonamides. Sulfonamide and prontosil were the preparations employed.

Only one patient treated with sulfonamides alone (this patient received sulfanilamide) failed to respond. Of 134 receiving sulfadiazine alone there were no deaths; in part this was due to the fact that with poor prognoses, penicillin was employed and if the patient expired the death was included with those occurring in the combined therapy group. Thus the overall mortality with sulfonamides must be considered to be 2.5 per cent. (Table IV.)

Two patients received penicillin alone with rather dramatic results. The remarkable antimeningococcal effect of penicillin was demonstrated by the first patient treated with penicillin alone—a 13 year old girl admitted with severe headache, stiff neck and vomiting. A spinal tap showed purulent fluid with absent sugar. Patient was placed on systemic penicillin 15,000 units every three hours and received one injection of 50,000 units intrathecally. She was asymptomatic on her sixth hospital day.

The use of penicillin alone was experimental and studies showing the inability of penicillin to penetrate the meninges caused us to aban-

ANALYSIS OF DEATHS

	Therapy	Age	Hospitalization	Admission Sp. Fluid Sug.	Admission Status
1.	Serum	2 Mo.	1 Day	Not det	Comatose
2.	Serum	4 Yrs.	1 Day	0	Comatose
3.	Serum	18 Yrs.	1 Day	0	Comatose
4.	Serum	8 Mo.	16 Days	Qual Pres.	Comatose
5.	Serum	51 Yrs.	3 Days	0	Semi-comatose
6.	Serum	20 Yrs.	3 Days	0	Conscious
7.	Serum	6 Yrs.	10 Days	0	Conscious
8.	Serum and Sulfanilamide	60 Yrs.	7 Days	50 mg.%	Conscious
9.	Serum and Prontosil	48 Yrs.	3 Days	0	Comatose
10.	Sulfanilamide	3 Yrs.	1 Day	0	Comatose
11.	Sulfadiaz. and Penicillin	65 Yrs.	5 Days	Less 10mg.%	Comatose
12.	Sulfadiaz. and Penicillin	80 Yrs.	7 Days	Less 10mg.%	Comatose
13.	Sulfadiaz. and Penicillin	20 Yrs.	3 Days	Less 10mg.%	Comatose

Table III

don it as the sole antibacterial agent in the individual patient. Also, results with sulfadiazine were so good that penicillin-sulfa combined therapy has been employed only electively, i. e. where the prognosis was poorer because of the criteria mentioned.

COMPARATIVE MORTALITY RATES

Agent Used	Number of Cases	Deaths	Mortality
Serum	30	7	23.3 %
Serum and Sulfonamides	3	2	66.6 %
Sulfonamides	144	1	.68%
Sulfadiazine and Penicillin	15	3	20.0 %
Penicillin	2	0	0

TABLE IV

therapy the lack of correlation between state of consciousness and spinal fluid sugar becomes obvious. Nevertheless the gravity of the disease process is registered, permitting some objectivity of classification.

COMMENT

Criteria for selecting a chemotherapeutic agent should include (1) its potency as an antibacterial substance, (2) ease of administration and (3) toxicity. The high toxicity of sera make them undesirable, particularly in the acutely ill patient. Difficulty in administration of penicillin (in view of necessity for intrathecal therapy) prevents acceptance of this as the ideal therapeutic agent. While toxicity mitigates against sulfonamides, in the individual patient its ease of administration and potency make it the preferred agent when carefully controlled; especially since penicillin is usable as an adjunct. Pharmacologic studies indicate the efficacy of both sulfadiazine and sulfamerazine but we have not used the latter. Our data indicate that heroic treatment is needed in patients with spinal fluid sugar of less than 10 milligrams per cent, in patients over 50 years of age or under one, and in patients unconscious on admission. The *in vitro* demonstration of different modes of action of the sulfonamides and penicillin, and the clinically better results obtained in combined therapy are adequate reasons for employing both of these agents in such patients.

With the synthesis of penicillin and separation into its varying fractions there is promise of more precise control of infection and some

PATIENTS RECEIVING COMBINED SULFADIAZINE AND PENICILLIN THERAPY

	Age	Adm. Status	Sp. Fluid Sugar	Period of Hosp. in Days	Results
1.	53 Yrs.	Comatose	0	21	Living
2.	7 Yrs.	Comatose	Less 10 mg %	16	Living
3.	13 Yrs.	Comatose	77 mg %	17	Living
4.	10 Yrs.	Conscious	0	13	Living
5.	80 Yrs.	Comatose	Less 10 mg %	7	Died
6.	40 Yrs.	Delirious	22.1mg %	19	Living
7.	32 Yrs.	Delirious	29.4mg %	21	Living
8.	48 Yrs.	Conscious	40 mg %	9	Living
9.	4 Mo.	Conscious	Less 10 mg %	13	Living
10.	11 Mo.	Stuporous	45.7mg %	8	Living
11.	65 Yrs.	Comatose	Less 10 mg %	5	Died
12.	18 Yrs.	Conscious	Less 10 mg %	12	Living
13.	10 Mo.	Conscious	30 mg %	5	Living
14.	20 Yrs.	Comatose	Less 10 mg %	3	Died
15.	9 Yrs.	Comatose	Less 10 mg %	**	Living

TABLE V

** Prolonged hospitalization for amputation of both lower extremities because of gangrene incident to fulminating purpura and peripheral circulatory collapse. To be reported in detail by Pediatrics Department.

Among patients receiving combined therapy, it was felt that penicillin adjunctive therapy was life saving in most cases. The high mortality (20 per cent) simply reflects the gravity of their illness. Thirteen (86.6 per cent) of this group had abnormal sensoria; five (33 per cent) were in the extreme age groups; and nine (60 per cent) had spinal fluid sugars under 10 milligrams per cent. One died of an overwhelming infection, one of uremia and one of acute pulmonary edema. The patient dying of an overwhelming infection was a twenty year old girl moribund when admitted. Institution of earlier therapy might have controlled the meningitis. Uremia and pulmonary edema were complications in patients eighty and sixty-five years of age, respectively.

From data on patients receiving combined

fraction of this drug or other antibiotic to be synthesized may prove ideal. Furthermore, the problem of bacterial drug fastness and host reactivity may be clarified. In view of this, and anticipating advances permitting specific therapy of the other bacterial meningitidies, the necessity for bacteriologic identification of the infecting organism is of paramount importance.

CONCLUSIONS

1. Of the currently available agents, sulfadiazine (or sulfamerazine) is the drug of choice for routine therapy in meningococcic meningitis. This is because of its ease of administration and clinically demonstrated potent antibacterial activity.

2. Penicillin should be used instead of sulfadiazine in patients who develope significant reactions to sulfonamides, where organisms are sulfonamide-resistant, or where sulfonamides are contraindicated because of primary or secondary renal functional impairment.

3. Penicillin should be used as a supplement to sulfadiazine in patients with spinal fluid sugars less than 10 milligrams per cent in patients over 50 years of age or under one; and when the patient was unconscious at the start of the treatment regime.

4. When penicillin is used, it should be given both intrathecally and systemically.

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79 Prospect Street

USPHS COMMISSIONS AVAILABLE

Competitive examinations will be held in New York City on March 31 to fill 75 vacancies in the United States Public Health Service. Commissions are available to physicians specially trained in bacteriology, parasitology, biochemistry and psychiatry. Salary varies between $3800 and $4800 a year, plus the usual incidentals available in the commissioned service of the United States, including disability, retirement at three-quarters base pay, 30 days annual leave with pay, and periodic promotions.

Inquiries and requests for application blanks should be directed to the Surgeon General, United States Public Health Service, Washington 25, D. C.

MEDICAL ESSAY CONTEST

The Mississippi Valley Medical Society announces a $100 prize contest for the best unpublished essay on medical science, medical economics or medical education of value to the general practitioner. The winner will be invited to present his contribution to the Annual Meeting of the Society in Iowa in October. Maximum length of contributions is 5,000 words, and the deadline is May 1, 1947. Further details are obtained from Dr. Harold Swanberg, Room 209, WCU Building, Quincy, Illinois.

SCABIES AMONG THE WELL-WASHED

Sidney Friedenberg, M.D., Camden, N. J.

The smug assumption that scabies is a disease limited to the great unwashed needs to be revised. It may be found among clean and dainty private patients too. Indeed, since my return from service, I have found that this disease is more common in office practice and that its manifestations are more likely to be atypical than was the case a few years ago. This increase, in part at least, may be due to the return of soldiers from Europe harboring unsuspected guests who have come uninvited for an American dinner. Frequently these men have taken a prescribed course of treatment for scabies and have been pronounced cured.

The perspiring skin is a perfect invitation to the ubiquitous parasite. I have seen two U.S.O. hostesses whose only contact with soldiers has been through dancing. With modern dancing, contact points are not limited to the hands.

The symptoms of scabies may not be "typical" among Americans habituated to frequent baths with soap and hot water, both rare European luxuries at present. Always suspicious in the history is severe nocturnal itching. Only a few scattered vesicles or papules may reward the search. A reddened papule on the penis may be the only diagnostic sign. Secondary infection and impetigo are common only in the child. Impetigo of a child's buttocks is to be considered scabies until proved otherwise. Obscure cases may be clarified by a search between the webs of the fingers or any part of the body for two adjoining vesicles. The examiner should then look with a hand lens: finding of a zig-zag burrow between two adjoining vesicles clinches the diagnosis and obviates the necessity of tests to determine the cause of a pruritis.

TREATMENT

Secondary infection should be treated first. Boric acid solution soaks locally and sulfathiazole in full doses orally are satisfactory if there is any evidence of toxicity or spreading infection. Despite the fact that the lesions are not yet clean, treatment for scabies should be begun after forty-eight hours.

The treatment of choice, in my experience, is 25 per cent emulsion of benzyl benzoate. Several pharmaceutical houses have recently offered preparations such as Zylate (Upjohn), Scabenate (Hart), and Emulsion of Benzyl Benzoate (Burroughs Wellcome). The latter preparation was the one used overseas. The newer ones claim more efficiency, but any preparation is efficient if used properly. The dry skin should be treated with an ointment or emulsion.

Three applications of 25 per cent benzyl benzoate emulsion should be made within twenty-four hours, the treatment being preceded and followed by a thorough bath. All clothing previously worn should be boiled or dry-cleaned, although no one as far as I know has ever found the *scabiei* in clothing or blankets. Every authority incriminates them, however. Blankets may be aired in the sunlight.

Adults should apply the lotion from the chin down. Males should not omit the genitalia.

Patients should be warned that if the emulsion seems to irritate or if redness of the skin appears, no more treatment should be undertaken for the time being. Some skins are especially sensitive to benzyl benzoate and it must be used with caution. Even 10 per cent is often irritating to a baby's skin, and, therefore, the baby had best be treated with sulfur ointment in one-to-four strength. The ointment must be applied to the face and scalp of babies.

Itching often persists after the parasite has been eradicated. A soothing lotion may be prescribed following the treatment course. If the skin is dry, an ointment such as the following is recommended:

℞ Phenol 0.40
Menthol 0.03
Hydrophilic ointment (NJF) 60.0

If success does not follow the first course of treatment it is not wise to try and try again.

Overtreatment dermititis is the most frequent complication of scabies. Wait and attempt to soothe both the skin and the patient. At least ten days should pass before another course of either benzyl benzoate or sulfur is tried.

If after apparent success a new crop of vesicles appears, there are two things to do. *First,* the lesions should be painted with compound tincture of benzoin which is a soothing mild scabicide; *second,* each member of the family should be inspected for a possible source; an apparent innocent member may be the home grounds of the *acarus scabiei.*

Urticaria, not so common in the young, is occasionally seen some six weeks after the onset. This is probably a sensitization phenomenon. Benadryl, 50 milligrams, four times a day, is of aid.

2990 Alabama Road

OBJECTIVE MEASUREMENT OF FATIGUE

A test to evaluate weakness and fatigue in patients with anxiety and neurasthenic psychoneurosis is described by Van Amberg. The patient is instructed to hold his arms extended to the side, shoulder high, for seven minutes. He is considered capable of average effort if shoulder ache fails to develop in two minutes; if tremors do not appear in the arms before three minutes, in the fingers before four minutes, and in the thighs before five minutes; if evident struggle is not present before five minutes; and if he can endure the exercise the full seven minutes.—Occup. Med. 1:363 (1946).

TREATMENT OF IVY POISONING

Poison ivy affects only those persons who have been sensitized to it by previous exposures, according to Lester Hollander, M.D., of Pittsburgh, Pa.

Writing in *Hygeia,* Dr. Hollander, who has been medical director of the Pittsburgh Skin and Cancer Foundation since 1923, says:.

"Poison of poison ivy is a sensitizing agent. It does not affect every one adversely. Even those in whom it causes a dermatitis are not afflicted by it the first or perhaps the second time they come in contact with it. After the epidermal cells have become sensitized to this poison by several contacts, it creates in many individuals a sensitivity that results in blisters, swelling and inflammation of the skin."

Usually the symptoms appear four to ten days after exposure, the author states. However, the more frequently the patient had previously suffered from poison ivy poisoning the quicker the symptoms appear. "Not only will the skin react sooner in such patients, but the irritation will also be more intense, dynamic, lengthy and uncomfortable."

"Some experienced medical practitioners maintain that dermatitis venenata caused by poison ivy is preventable by immunization. Extracts of the poison plant are administered either by mouth or by hypodermic injections. At present, the injection method finds the greatest number of adherents."

The author's suggestions for the prevention of poison ivy poisoning include recognizing the poisonous plants, refraining from touching them or letting clothing come in contact with them, keeping away from the smoke of burning weeds or brush and on outings wearing clothes that cover the arms and legs.

Once the skin inflammation is present, the object of treatment should be:

To alleviate the itching and burning of the affected parts; to hasten the drying of the blisters; to facilitate the reduction of the skin inflammation; to counteract secondary infection, if present; to return the skin to its normal condition.

These objectives can be achieved by the application of wet compresses immersed in either Burow's solution, liquor aluminum acetate or boracic acid. Potassium permanganate baths are of value in counteracting secondary infections, usually caused by scratching, which may appear with the formation of pustules or even boils. Severe attacks of poison ivy may be followed by the development of a series of boils, the article says. In that case the best and quickest treatment consists of giving injections of penicillin into the muscles.

MATERNAL MORTALITY — SOME ASPECTS OF ITS PREVENTABILITY*

James Francis Norton, M.D., F.A.C.S., and Edith K. Mangone, M.D.
Margaret Hague Maternity Hospital, Jersey City, New Jersey

I would like to discuss with you today in some detail what appears to me, to be one of the most important aspects of the preventability of maternal mortality. The observations here offered you are predicated upon a detailed maternal mortality survey which I had occasion some time ago to undertake. I will not burden you with any analysis of figures. I will not compare our results in Jersey City with any other set of figures. Rather do I wish to tell you where our greatest amount of difficulty occurred, why it seemed to occur, and then to indicate to you how I think there may be prevented in the future a recurrence of the untoward occurrence which we are here studying.

For the basis of this presentation, I have selected sixty-one cases of maternal death which occurred at the Margaret Hague Maternity Hospital in each of which there seems to have been some degree of preventability.

PUERPERAL INFECTION

It is very difficult accurately to assess the factor of preventability in puerperal infection. There are so many vague intangible and not too easily assessable factors involved to prevent easy and ready unanimity of opinion. In evaluating responsibility for puerperal infection, I feel that unless a definitely known and proved endogenous source of infection existed, or unless one can establish an exogenous source in no way associated with hospital management or personnel, then the death should be deemed preventible. I know that this will result in one assuming responsibility in some cases in which in fact he has no real responsibility, but as I see the problem, unless this is the attitude adopted, any good that might accrue from this or similar studies would be vitiated.

Today, in spite of all that is known and taught concerning good technic, in spite of our increased knowledge of chemotherapy, puerperal infection remains, as a very formidable factor in obstetrics. Of the fatal cases of puerperal infection with normal spontaneous delivery in our series, four were probably preventable, and the source of the infection was undoubtedly associated with obstetrical interference. In two cases, there were baggings; one patient having been in labor for a long time; and in a third case, an operative interference, a draining of a presumed pelvic abscess was undertaken on the 45th postpartum day, during the course of a prolonged clinical puerperal infection. Perhaps this was an operative procedure injudiciously undertaken. The fourth case, again one of operative interference, had a reconstruction of an old laceration of the sphincter ani, after the completion of the third stage of labor. This too was probably a case of unwarranted surgical manipulation. This suggests that injudicious, not too sharply indicated, and not too sharply defined surgical interference is not to be undertaken. Therefore, in all four of these cases, some meddlesome interference was present which might well, in each case, explain the subsequent untoward course.

I would like to discuss the question of infection following Cesarean section as revealed by a survey of ten fatal cases. Each of these is deemed to be preventable, unless some definite and unquestionable focus of infection (other than the operation) is firmly established. Here too, some other questions must be answered: (1) Was the operation truly indicated? (2) Was the type of operation the one best suited for the case? (3) Was any serious contraindication to Cesarean section present?

In all ten of these Cesarean sections, cephalopelvic disproportion was the indication, except in one case where a transverse presentation was the indication. There were four low transverse cervical Cesarean sections; there was one classical Cesarean section in 1934; one Beck type of exteriorization; two Latzko extraperitoneal; and two supravesical extraperi-

* Read before the Annual Meeting, The Medical Society of New Jersey, May 22, 1946.

toneal Cesarean sections. In all cases, the patient had been in labor for a long time, the membranes had been ruptured a long time, except in one which was undertaken electively with no labor and no period of ruptured membranes, who shortly after the operation had a rise in temperature and died on the fourth postpartum day with puerperal infection. The duration of labor in the other patients ranged from nineteen to sixty hours, and the duration of periods of ruptured membranes from sixteen to fifty-five hours.

Expressing my own views alone, I am of the opinion that transperitoneal Cesarean section should be done only in the highly elective type of patient who has not been in labor, and who has had no period of ruptured membranes, or, at best, a very short period of labor with an equally short period of ruptured membranes —not more than eight hours of labor, and certainly not more than eight hours of labor with eight hours of ruptured membranes. All other cases fall into either the potentially infected or the frankly infected group, and if they are to come to Cesarean section, should be approached from an extraperitoneal route.

Of our total puerperal infection deaths, five patients were delivered by forceps operation. There was nothing of any unusual moment in the past history of any of these to explain the subsequent course. Two had antepartum morbidity or intrapartum morbidity, and one was in labor for eighty-two hours. As was indicated in the comment above concerning puerperal infection following Cesarean section, since there was no other ascribable focus for any of these infected courses, we accept all five as preventable.

Now, what is the best treatment to offer these patients prophylactically? It is now definitely established that the administration of some of the sulfonamides, perhaps sulfadiazine, combined with penicillin, to the patient long in labor, and with ruptured membranes, and who is potentially infected, is probably going to result in some diminution in puerperal infection. Of course, in the actual active treatment, after the establishment of the infection, the patient should be isolated. An attempt should be made to isolate the offending organism by cervical culture, and if possible, of course by blood cultures. Specific therapy in the form of either penicillin or again sulfadiazine, or sulfanilamide, depending upon the organism isolated, is the treatment of choice. Transfusions today, as before, holds a very important place in the clinical management of puerperal infection. Good nursing care is absolutely essential.

ECLAMPSIA

I believe that most cases of eclampsia are preventable. There are some exceptions, of course, to this statement, but they are definitely few. The early presence of albumin, edema, or hypertension must be recognized and fully evaluated. The preventibility of eclamsia is, in the main, easy and inexpensive. It requires no more than a Bunsen burner, a set of scales, and a sphygmomanometer. It does require, however, and there is no substitute for it, an attitude of mental alertness and awareness on the part of the doctor caring for these patients.

Clinical management goes back to the antepartum course, or rather to the ante-convulsive course. Essence of the treatment is to prevent convulsions. The mortality from pre-eclampsia is about one-half of one per cent. The mortality from eclampsia varies from eight to ten per cent. In other words, if the doctor waits until the patient has a urine that boils solid with albumin, if he waits until she has a massive edema, or a blood pressure in the high one hundred and nineties, or perhaps in the two hundreds, he has waited too long; a convulsion is imminent, and the patient's chances have been very seriously compromised.

In two deaths in clinic patients from eclampsia, it was thought that the hospital might well have been at fault. In one, the early but definite signs of toxemia were not heeded, and in another, we waited too long with a patient with a severe pre-eclampsia. Among eight patients in the non-clinic group, the outcome was thought to be preventible, and in all eight the patient was admitted to the hospital in coma. Of the four private cases, in three the patient was admitted to the hospital in coma. In one of these, as in one of the clinic cases, a severe

pre-eclampsia was treated expectantly for too long a period and it eventuated in eclampsia. The two clinic cases in this series against eight non-clinic and four private patients, emphasize the fact that the management and care given the clinic cases of pre-eclampsia is likely to avert eclampsia in most instances.

Now what is our clinic care for the patient with pre-eclampsia—albumin—hypertension—edema? Admission to the hospital at the earliest possible time to treat adequately the pre-eclampsia is the only method from which one may expect the desired results. This means close but not too prolonged supervision and hospitalization for as long a period of time as is deemed necessary. This leaves us with a definite element of preventability in fourteen of these cases.

In viewing this material, some interesting questions may be asked. Should a patient with severe pre-eclampsia ever be discharged from the hospital before delivery? It is my thought that no pre-eclamptic of a severe nature should ever be treated at home. Once a diagnosis of severe pre-eclampsia is made, a patient should never be discharged from the hospital until her delivery is completed. The only treatment for this is (1) early detection of the toxemia, which depends on recognition of, and the significance of, the presence of albuminuria, edema or hypertension. There then follows (2) the earlier and longer period of antepartum bed rest with energetic treatment, preferably in the hospital. Next (3) the termination of the pregnancy if the toxemia does not improve under vigorous treatment within a reasonable period of time. What is a reasonable period of time? The essence of the management depends on the early recognition of pre-eclampsia, with the determination of preventing the progression of the toxemia to the state of the actual eclampsia.

HEMORRHAGE

In attempting to evaluate the problem of preventability in a group of obstetrical hemorrhages, certain very real difficulties present themselves. In a patient with no untoward past history and a normal pregnancy, with a not too long labor, and either a normal spontaneous delivery, or a relatively easy forceps operation, who immediately or some few hours postpartum, begins bleeding briskly from the vulva, oxytoxics, transfusions plus other supplemental fluids are used; inspection and examination of the birth canal for lacerations is made, and, if need be, a hysterectomy is performed in order to control a hemorrhage which bids fair to go on and terminate fatally. In spite of the early, prompt and widespread use of all the available instruments at the disposal of the attendant in a well equipped and completely manned institution, death ensues. Is a death of this nature preventible or non-preventible? We feel that in the absence of errors of clinical judgment, such a death, under the circumstances set forth, is non-preventible.

Accepting these fundamental criteria as true, five cases are considered to be preventable.

ABRUPTION

Complete abruption of the placenta is probably the most catastrophic clinical entity in the entire field of obstetrics. When one attempts to discuss the element of preventability in this group, many hazards present themselves. We must examine carefully whether the underlying toxemia, if one was present, was treated adequately; whether appropriate selection was made as to time and type of delivery and anesthesia; and finally, whether all provisions were made properly and energetically to handle the hemorrhage, the accompanying shock, and the postpartum complications present. With this in mind, I feel that one patient with abruption had a preventable death. This was a patient with nephritic toxemia who was in the hospital for three weeks and was being carried along when she abrupted her placenta. Here, I feel, we may have waited too long.

The question of whether Cesarean section or delivery through the birth canal is better, one cannot answer from this one fatal case. However, three other fatal cases of our group, at postmortem examination, had considerable hemorrhage into the peritoneal cavity, and into the uterus, and sometimes extending out into the broad ligament. The discovery of such a pathologic state is possible only if one elects to do a Cesarean section. The possibility of this

complication has in many instances determined our choice in the method of delivery.

POSTOPERATIVE HEMORRHAGES

There were two postoperative deaths from hemorrhage following Cesarean section, and in one of these there was an error in operative technic. In 1936, a forty-five-year-old quadrigravida with rheumatic heart disease had an elective section with tubal sterilization and expired twelve hours after operation. At postmortem examination, there was found an extensive hemo-peritoneum. Clinically, she was thought to have had post-operative cardiac collapse secondary to her rheumatic heart disease. The second patient died during an operation, due to an error in judgment in that the exact amount of bleeding was not properly assessed at the time of operation by the operator. This patient was a thirty-five-year-old primigravida who, during the course of a Latzko Cesarean section, expired on the table from hemorrhage.

There are some basic criteria for the adequate management of all bleeding cases in the last trimester of pregnancy which I would like to emphasize. They should be hospitalized, all of them, for study, in order to determine the exact source and amount of bleeding, the status of the cervix, and the position of the placenta. They should be typed, cross-matched, and donors made available. There would be no rectal examination, no vaginal examination carried out, unless in the operating room, which is completely set up and immediately made available for the completion of the delivery by Cesarean section if any untoward amount of hemorrhage is encountered.

RHEUMATIC HEART DISEASE

I will discuss ten deaths from rheumatic heart disease. In one clinic case a hysterotomy was undertaken before the patient had fully recovered stability of her cardiovascular tonus, and a second clinic patient was discharged from the hospital (contrary to our principles of management) by a new cardiologist substituting for our attending cardiologist who was on active military duty. In two other clinic cases, both patients refused to cooperate and abide by the instructions and advice given them, and the responsibility for the failure is definitely theirs. Both these patients were difficult to manage, and neither one was ever reduced to what we regard as complete control by the hospital staff.

There were three private patients in this group of rheumatic heart disease in whom the outcome was probably preventable. There were three nonclinic cases, and in two cases another hospital is responsible, having in both instances admitted the patient in failure and then discharged her with her status improved. In neither case was the patient given any instructions as to further care or advised to register in the antepartum clinic of this hospital, thus permitting, of course, the patient to escape our control. The third nonclinic patient refused to register in the antepartum clinic because she feared she would be hospitalized for her present signs of failure as she had been in her previous pregnancy for fourteen weeks, again avoiding close control.

We have therefore in all our clinic experience with rheumatic heart disease an element of preventability in only two cases, as far as our own hospital is concerned, and in three cases, as it relates to the private physician. We feel no sense of reproach for the untoward outcome in the nonclinic patients.

Our criteria of adequate care for the pregnant cardiac necessitates the making available to patients of this type, at the earliest signs of decompensation, facilities for prolonged periods of complete antepartum bed rest, running in some cases for as long as six months. It is our definite feeling that only by this method can one decrease the incidence of serious failure and eventually death in pregnancy complicated with rheumatic heart disease.

If this period of prolonged bed rest for the patient with pregnancy complicating rheumatic heart disease proves to be a severe economic problem for either the patient or the hospital caring for these patients, then perhaps the time is near at hand when what is considered the basic needs of these patients might well prove to be more of a socio-economic problem than one of medical management.

Viewing the overall clinical picture of pregnancy as we have seen it in rheumatic heart dis-

ease we can say that of fourteen such deaths (grouping together the aforementioned preventable with a group of non-preventable issues) that two delivered at home were admitted for advanced terminal failure. Five died undelivered. Of this total of fourteen cases, nine were admitted in advanced failure; one died three and a half hours after admission, another nineteen hours, the other fifteen hours, twelve hours, sixteen hours, three hours, eleven hours, eight hours, two and a half hours. This definitely emphasizes the tremendous gravity of the problem of advanced heart failure in pregnant patients with rheumatic heart disease.

Patients with rheumatic heart disease die during pregnancy and the puerperium because of heart failure. The treatment of rheumatic heart disease, therefore, is the prevention of heart failure, and not waiting to treat failure after it has occurred. Once the early signs of failure develop, cough, dyspnea, or cyanosis has appeared, the treatment which we have found best suited is immediate hospitalization with complete bed rest for the duration of the pregnancy.

Three criteria, all taken from the history, have very definitely in our work indicated those patients most likely to fail: (1) Any patient over thirty years of age; (2) the pre-pregnancy functional classification of heart disease—the severer the pre-functional classification, the more likely is the patient to fail; and (3) a history of previous failure at any time, whether in this pregnancy or not. The keynote of prevention is a good history, eliciting the age, determining the pre-pregnancy classification, and eliciting the history of any previous failure. That, plus good control of the patient after she has come under observation.

Now what does good control mean? Good control means regular, repeated, and close observation for the very earliest signs of failure (as cough, dyspnea, cyanosis and edema), and admitting the patient to the hospital for the duration of the pregnancy once any of these signs develop. Good control for the clinic or private patient demands the association of a competent cardiologist in the care of these patients.

There were but two deaths in our entire experience up to 1944 where all these factors were observed and where the patient was under good control.

Fitzgerald, reporting from the Cook County Hospital recently, said that they had but two deaths in the past seventeen years at their hospital in patients with rheumatic heart disease over whom they were able to exercise complete control.

RUPTURE OF THE UTERUS

Among the nine cases of rupture of the uterus in our series, the patients varied in age from 26 to 40. There were eight multigravidas and one primigravida. Five of these were clinic patients. The past medical and obstetric histories were not of particular significance, except that, on the whole, they all had large babies during their previous pregnancies. Two of the nine had transverse presentations intrapartum, one of them with a prolapsed cord. The most significant factor in the whole analysis is that six of the nine had podalic versions with breech extractions. Two others went into shock during labor and had the clinical picture of a rupture of the lower uterine segment, as seen in obstructive labor after the development of a Bandyl's ring. All nine resulted in stillbirths. The site of the tear was in the lower uterine segment from an extension of a cervical tear in six of the patients, the lower uterine segment at the site of reflection of the peritoneum from the bladder into the uterus in two patients, and on the posterior surface of the lower uterine segment in one patient.

The one factor that stands out most prominently is that version in multiparae with previous lacerations of the cervix may result, and often does result, in extension of a previous cervical tear up into the lower uterine segment with fatal consequences. This happened in six of the nine cases here presented.

Transverse presentations and emergency bleeding supposedly requiring internal podalic version, producing extension of cervical tears, or a Bandyl's ring as a result of obstructive labor, are the pitfalls to be avoided and watched for in rupture of the uterus.

We had one death from inversion of the uterus. I mention it only to indicate that shock

following delivery demands exploration of the entire birth tract including the uterine cavity, if no other easily ascribable cause can be found. If this had been done in the case indicated, the inversion would have been detected and corrected, and the fatality avoided. This patient had rheumatic heart disease, and the shock was thought to be due to cardiac collapse, when as a matter of fact, it was due to an acute, complete inversion of the uterus.

I would like to mention, in passing, three cases of intestinal obstruction. Beware of the individual who is thought to be in labor, at term, with an abdominal scare who is having reasonable regularly recurring pains, who is making no progress in her labor! She may well be having, as we have seen, the development of an intestinal obstruction.

CONCLUSIONS

In reviewing the preventable aspects of maternal mortality as seen in one large obstetrical hospital, certain definite factors seem prominently to stand out: Puerperal infection; eclampsia; hemorrhage; rheumatic heart disease; and rupture of the uterus offer the greatest hope for some further definite reduction in our maternal mortality.

Puerperal infection: It has been shown again that meddlesome interfering, bagging or forceps during labor is not good obstetrics. Unnecessary surgery, reconstruction of an old perineal laceration, and the surgical treatment for prolonged puerperal infection can be avoided. Some hope for further reduction in the incidence of puerperal infection may be anticipated by the use in labor of sulfa therapy plus penicillin in those patients long in labor with membranes ruptured. For Cesarean section there should be a better selection of cases, a better selection of the type of operation—low cervical approach transperitoneally for the absolutely clean case, for the patient in labor but a very short time; extraperitoneal approach for those potentially or actually infected. No matter what type of delivery one discusses, long labor and long periods of ruptured membranes, hold a real hazard and should be treated intrapartum with sulfa and penicillin.

Eclampsia: The timely diagnosis of early pre-eclampsia is imperative. Regular meticulous examination of the urine should be made for albumin. Other signs are: a blood pressure elevation of, or exceeding 140/90, and edema as revealed by weight. More alert responsibility is needed towards all pregnant patients who show any increase in their blood pressure, exhibit inordinate weight gain, or have albuminuria. Immediate admission to the hospital for further treatment is recommended while the case is still amenable to treatment. Also to be considered is termination of the pregnancy by means most suited, for those who do not respond reasonably early to good hospital management. The problem here is to prevent the convulsion, and in the vast majority of cases this can be done. Once the convulsion is superimposed, you have increased the maternal mortality risk ten times.

Hemorrhage: There should be immediate admission to the hospital of all bleeding cases in the last trimester of pregnancy. You cannot adequately treat placenta previa, abruption of the placenta, or postpartum hemorrhage at home. You need at least (1) an operating room for examination, and if need be, for abdominal delivery; (2) a laboratory for routine typing, cross-matching, Rh factor on all patients; (3) donors on hand immediately for transfusion; (4) need for trained help. No one person alone can adequately do all these things. Strict adherence to the foregoing regime has effected some reduction in the hazards associated with the bleeding state in our hand, and its more widespread utilization will effect a still greater reduction.

Rupture of the Uterus: Beware of internal podalic version in any case, bleeding or otherwise, in a multipara who probably has had an old cervical laceration. You are inviting an extension of the laceration up into the lower uterine segment with fatal consequences. This happened six times in our experience. More time should be spent in a more detailed and clinical study of these patients before any interference is undertaken. The emergency may not be as real as presumed. Rupture of the uterus still occurs in obstructive labor, after the formation of a Bandyl's ring. Earlier intervention in the patient long in labor, before the inordi-

nate thinning out of the lower uterine segment, is the only hope for prevention.

Do a pelvic examination on the postpartum patient, bleeding and in shock. You may be dealing with an unrecognized inversion of the uterus. This is what was not done in the only death from inversion in our hospital. You may have a laceration of the cervix; you may have a rupture of the uterus; you may have a laceration of the bulb of the vestibule; you may have to do an immediate hysterectomy. Do a complete pelvic examination.

Beware of the patient in labor with an abdominal scar who is having abdominal pain, regularly recurring, who is not making adequate and satisfactory progress as far as labor is concerned. You may find out all too late that the pains are not due to uterine contractions, but are due to intestinal obstruction. We have seen three such cases.

Finally, would I urge upon you, the utilization of consultative advice. The obstetrician alone can not handle these problems. He needs a competent cardiologist. He has need for, often enough, a competent urologist. He needs surgical help. He needs the help of a trained internist. But most of all he needs help.

Of those states most likely to yield some reduction in mortality I would like to point out that the patient very often gets into serious difficulty before delivery, sometimes before labor. Infection during long labor, poorly selected type of operative delivery, the failure to recognize and treat energetically enough pre-eclampsia; the failure to make preparations for handling hemorrhage, the mistake of not preventing failure in rheumatic heart disease.

Many years ago, I heard an old doctor say that all obstetrics could be divided into two classes: One, comprising by far the vast majority of all patients, needed no doctor at all—they had no complications of pregnancy—they had no complication of labor—they had an easy normal delivery, and a normal puerperal course. They just did very well. The other, a much smaller group, needed not one doctor, but at least two very good doctors. I think that this is as true today as it was then, and the more one sees of difficult, complicated obstetrics, the more he is convinced that this is not the job of one man alone but the job of at least two good men.

58 Kensington Ave.
174 Clinton Ave.

SULFATHIAZOLE JELLY

Intravaginal medication is facilitated by a sulfathiazole polyethylene glycol acid jelly that is adhesive and semi-liquid at body temperature and is completely soluble in secretions. A disposal paper applicator simplifies office treatment. Siegler reports excellent results in 93% of patients with vaginitis of trichomonal, monilial, gonococcal, or nonspecific origin, with permanent cures in 83%. The jelly was also efficacious in treatment of patients with cervical infections. Use of the jelly before and after conization, coagulation, cautery plastic repairs, and other intravaginal surgery shortens convalescence.—Am. J. Obst. & Gynec, 52:1 (1946).

SYMPATHECTOMY FOR UTERINE CANCER

In treatment of basal cell carcinomas of the cervix uteri, effects of radium are enhanced when circulation to the uterus is increased by a block of the lumbar sympathetic chain. Of 28 patients in whom hyperemia of the uterus was provoked by repeated lumbar anesthetic blocks with procaine hydrochloride of the first, second, and third lumbar ganglions, 17 were improved, reports A. de Pereira. Only 16 of 34 patients treated without lumbar block were improved. Lumbar block also relieved uterine pain.—Arch. Surg. 52:260 (1946).

A SUCCESSFUL FINANCIAL PLAN FOR GROUP PRACTICE

By Maynard G. Bensley, M.D., and
Cedric C Carpenter, M.D., Summit, N. J.

Although many articles[1] have appeared stressing the advantages to both patients and doctors of the practice of group medicine, we have been unable to find any detailed accounts of a sound financial structure on which a group should be formed. Yet it is well recognized[2] that "when this system has failed, the fault in most instances has been the organizational structure, the division of income and expenses, or the antagonism of the profession". It has been of interest to note that many of the questions directed to us by interested physicians have had to do with our financial methods, and it is the purpose of this paper to present our system. We hope that it will save new groups some of the "headaches and growing pains" we have experienced in the past eighteen years in expanding from a three to a nineteen doctor partnership, and in having made two large additions to our building.

After two or more doctors have agreed to start a group, their first concern should be to get together under one roof. This permits better liaison and economy and insures that diagnostic equipment and laboratory facilities will be available to each member. All equipment, real estate, fixtures and furniture used in the practice of the partners should be impartially appraised and credited to the capital share of the individual concerned. From then on, such appurtenances become the property of the group to use or dispose of as they wish.

A constitution and by-laws should then be adopted, to insure smoothness in operation and to outline the principles by which the associated doctors will be governed in the future. We believe that the following points are of paramount importance and should be included:

1. Practice under one roof and, preferably, ownership of the building.

2. Complete and accurate records of each patient should be filed in such a place that they will be easily obtained and shared by every member of the group. For this reason, we prefer the Presbyterian Hospital (New York) unit chart system[3] and a diagnostic file following the Standard Nomenclature, as an aid in the future study of the results of therapy.

3. One night in the week should be set aside as "sacred" for a meeting to discuss business and professional work, and prompt attendance should be required. A chairman and secretary should be elected. Reports and requisitions should be received from the committees or doctors in charge of finances, housing, employees, laboratory, library, etc., and approved by a majority vote after the necessary discussion. In this way all the partners are kept informed and have a voice in all the activities of the group. After the business session, guests may be invited to the professional discussion of interesting cases, journal club discussions or the presentation of papers, etc. A social get-together after these meetings offers an opportunity for informal discussions and for the ironing-out of any personal difficulties which may have arisen during the week. Once a year an annual meeting should be held for the election of officers and committees for the ensuing year.

4. New members may be elected only by unanimous consent of the members and should be carefully investigated for at least a month following the proposal of their names. They should be members of their state and county medical societies and, if they desire to limit their practices, should have certification by the American Board or its equivalent. All active members should live in the same locality and all their professional fees should be carried on the books of the group.

5. Associate members may live in adjacent communities. They are not eligible to be capital shareholders, in that their practices are not limited solely to the Group. Any member may resign on three months' written notice to the others; or his resignation may be demanded within three months on a written request signed by all the other members. Each mem-

ber agrees that he will not open an office in the same community if he should resign.

The services of a good lawyer should be secured in drawing up a partnership agreement, so that each member may have a copy signed by all the other members. In this document, the signers should agree to associate themselves as partners for a stipulated period of years and, in addition, clearly set forth their financial relations. Our present agreement has been in force now for seven years, and we suggest inclusion of the following points:

1. The partnership assets should include all real estate, fixtures, books, records, cash monies on deposit, accounts receivable and life insurance policies.

2. A statement of each partner's initial capital share, giving the total amount as derived from an impartial appraisal of his equipment, real estate, furniture, etc., and any cash money that he may have contributed. If a new agreement is being drawn, it should include also a statement of each partner's share in the undistributed profits from the old agreement.

3. A maximum value of a partnership capital share should be agreed upon and all partners with less than this amount should signify their willingness to contribute an equal share with the others by payroll deductions over a period of years, until the difference between their capital contributions and the total partnership share has been completed. It is our policy to deduct 10 per cent each month from the monies that the deficient partners are entitled to withdraw, but these men may contribute more at any time they wish.

4. No partner should be permitted to withdraw from his share in the capital account unless this is acceptable to all the other members. Arrangements should be made with the Finance Committee to make up this withdrawal as rapidly as possible, so that no financial hardship on the group will result.

5. No partner should be allowed to contribute more than the maximum amount of a partnership share without the consent of the remaining partners. Where, (in the early stages of the formation of a group) this may be necessary because of the age and financial position of some of the partners, it should be clearly stated that any amount above the equal partner's share may be refunded to them at any time, in cash, so that their shares will be reduced to the equal partner's level. This may be accomplished by new men entering the group and contributing to the capital share.

6. The finances and fiscal affairs of the group are to be managed by a Finance Committee, of three members, elected from those partners who hold a capital share at the annual meeting. It is their duty to see that full and complete records and books are maintained at all times and that *separate records* are kept of the fees billed and collected for each partner for the work that he has done. In addition, they have charge of all books and records concerning the partnership, finances, control of the collection of all monies, banking and distribution of the parnership fund. A complete audit should be made once a year by an accredited accountant.

7. The net profits of the partnership should be distributed as follows:

A. A sinking fund of 5 per cent of the gross income is first set aside to pay for premiums on life insurance taken out by the partners to cover their partnership shares and to be used for the purpose of buying a deceased partner's share from his estate. This sinking fund may be used for other purposes, such as addition to buildings, the purchase of expensive equipment, research funds, or as a good reserve, as decided by the group and Finance Committee. It should be understood that this percentage may be increased or decreased from time to time as is found necessary for these purposes.

B. After the above deposit in the sinking fund, there is paid to each partner from net profits interest of 8 per cent per annum upon his capital share. This should be done at least semi-annually.

C. Operating expenses, (which include maintenance, taxes, salaries of telephone operators, nurses, technicians, etc., as well as medical society dues, medical periodicals, gasoline and insurance for the doctors' cars and all other costs of operation) should be deducted next.

D. Each partner should then receive monthly the same percentage of fees collected for his account as is received by the other members. This percentage is to be determined by the Finance Committee from time to time, depending on operating costs or necessary additions to the sinking fund for the purchase of expensive equipment, etc. During the formative years it may be only 50-60 per cent of the fees collected on each account, but for the past several years we have been able to maintain this figure at 70 per cent with but few exceptions.

E. Undistributed profits are credited to each

partner's account in equal amounts. These profits consist of the difference between the gross income for the period and the sum of the four previous items, plus a reasonable allowance for depreciation, obsolescence of buildings, equipment, furniture and furnishings. As th partners have no actual share in these profits, any income tax expense to the individual because of his share is assumed by the partnership.

8. The life insurance policies which cover the partner's capital share in the group are payable to the partnership and each individual waives his right to change the beneficiary. The premiums are paid from the sinking fund and charged as an investment of the group. The proceeds of these policies are used for the purpose of paying the deceased partner's estate the value of his interest in the partnership, and any excess not required for this purpose belongs to the group. If, for any reason, the partner should withdraw from the group, he should be given a reasonable time within which to purchase this policy for its cash surrender value and to change the beneficiary. Otherwise, the policy is to revert to the partnership to be disposed of as desired.

9. In the event of a withdrawal from the group of any partner, or upon his death, it is understood that neither he nor his estate has any interest in any part of the furniture, fixtures or equipment, real estate, name or good will of the group. The financial condition of the partnership is determined at this time and the partner or his estate is paid the following:

A. The amount of the partner's contribution to the capital.

B. Interest at the rate of 8 per cent per annum upon the preceding sum of the unpaid balance computed to the date.

C. Accumulated percentage withdrawals standing to the credit of the partner.

D. For the first six months after the date of a partner's withdrawal or death, he, or his estate, is paid the same prevailing percentage of all fees received within that period. After this time has elapsed, a final settlemnt of thirty per cent is made on all fees receivable, the group retaining seventy per cent as an allowance for expenses for collection of uncollectable accounts.

E. The retiring partner, or his estate, is not entitled to any part of the sinking fund or undistributed profits.

10. In the event of death or retirement of a partner, the partnership should not be terminated, but continued under the same terms for the duration of the agreement.

11. If, for any reason, the partnership should terminate, a full and accurate inventory should be prepared of all assets. After all the debts have been paid, the remaining assets will be divided as follows:

A. Payment of each capital shareholder his respective contribution to the capital.

B. Payment of respective shares in the undistributed profits to each partner.

C. Accounts receivable will be used to satisfy the above items first and the balance divided among the partners in proportion to their respective percentage withdrawals.

12. All active partners agree to devote their full time and skill to the parnership, and will not sell their shares or any part of them, or enter into any agreement as the result of which any person, firm or corporation would become interested in the affairs of the group .

SUMMARY

A plan for the financial organization of medical groups has been presented which has been successful for a group which grew during the depression and remained active in spite of the fact that half of its membership served in the armed forces. It is believed that a similar plan will insure the success of any other group, as long as the individual doctors will cooperate in an ethical way with the solo practitioner, maintain close affiliation with the local hospital and spend some time each week in teaching clinics or other post-graduate endeavors.

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129 Summit Avenue

VETERANS CARE PLAN

PROTECT THE PHARMACIST

If you write a prescription for a veteran, and indicate by certificate that you are authorized to do so, the pharmacist will furnish the drug, and bill the Government. If the condition for which the Rx was written was not a service-connected disorder, the Government must refuse to reimburse the pharmacist. Result: the druggist has given from his own stock, gets no compensation, must bear the loss personally.

Here is how such a situation might arise. You are authorized to treat a veteran for, say, a recurrent bursitis. While treating him, you see he has a cold, and prescribe some nose drops. The rhinitis is not service-connected, and the VA of course will not pay you for treating it. That's all right with you, because you are being paid for treating the bursitis, and you don't mind writing a prescription for some nose drops as an incident to taking care of the veteran. You have been writing authorized prescriptions for this veteran for the bursitis, so more or less automatically, you prescribe the nose drops in the same way. That is, you make out the Rx in duplicate, and write the authorization certificate ("I certify that I am authorized to treat and prescribe for . . . etc. . ."). The druggist furnishes the nose-drops, sends his bill to the VA and, of course, reimbursement is refused. Nose drops are not appropriate for the treatment of bursitis.

Following is an extract of a letter from General Hawley on this point. Please notice the final, italicized sentence:

Under present law, outpatient treatment of veterans is limited to service connected conditions, except under certain specific circumstances. However, the fulfillment of our professional responsibility to eligible veterans necessarily involves medically adjunct, related and contributing conditions, to the extent possible under existing law.

It is requested that all Chief Medical Officers in Regional Offices under jurisdiction be informed of this concept of professional responsibility, particularly with respect to prescriptions submitted from state pharmaceutical associations. This point is especially important with respect to the reimbursement of pharmacists.

Pharmacists must accept prescriptions for veterans which carry proper VA authorization from physicians or dentists. If any medication is later determined to be altogether inappropriate for the condition authorized for treatment, or not reasonably attributable to such service connected condition, it is within the authority of finance officers to refuse payment for such pharmaceutical service. This imposes a serious and unfair penalty upon pharmacists acting in good faith. It is obvious that the participating pharmacist is without means to evaluate the extent of authority of the physician or dentist in terms of the nature of the condition properly under treatment. It is therefore, requested that your office take appropriate action to inform all participating physicians and dentists, that they must *be meticulous in ordering only such medication as can be considered reasonably appropriate for such patient in the light of the authorized service connected disability* and contributing or related conditions.

Very truly yours,
Paul R. Hawley,
Chief Medical Director.

VETERANS' PENSION EXAMINATION UNITS

February 12, 1947.

Veterans will be required by the Veterans Administration to undergo specialized types of physical examination. When necessary, VA will request that such examinations be performed by units organized by the Plans in the several counties. A physician interested in performing these examinations should communicate with the trustees of the Plan for Veterans Medical Care in his own county. Veterans Administration does not supervise the operation of these Plans.

The Regional Office of VA has received from Washington the approved contracts for Hudson, Monmouth, Middlesex, Passaic, Bergen, Ocean, Morris, Essex and Hunterdon-Warren Plans. Essex Plan will not make examinations until the load confronting VA warrants it. Contracts have been submitted to Central Office of VA in Washington for Union, Mercer and Gloucester Plans.

VA is establishing complete units of its own in Camden, Paterson, Union City, Trenton and Newark, although facilities of the Plans in these areas will be employed whenever necessary. Cape May will probably be served by Atlantic Plan. Camden wishes to establish a unit not associated with a hospital, which will require a different type of contract.

EXAMINATIONS FIT FOR RATING PURPOSES

Usually more than one physician will examine a veteran. Each physician should review the original authorization issued by VA

to note not only the types of examinations requested but also the previous diagnosis, which is a clue to the veteran's claim. All defects should be covered in the report and included in the final diagnosis. Conditions no longer present should be listed in the diagnosis as "no longer present".

Diagnoses prefixed with such terms as "probable" and "possible" are not acceptable.

Copies of the *Manual for Examining Physicians* are available to the units. The examining physician should check the manual relative to the defect to be considered so that he may learn what the Rating Board desires in his report. It is not necessary for a physician to read the entire manual. The index will guide him after a general familiarization with the contents and method of arrangement of the material.

Regardless of the number of physicians making the examinations, only one report form will be used, except for laboratory, x-ray, EENT, and electro-cardiograph reports. Each physician will record his findings in the appropriate spaces. He will also supply a diagnosis at the end of the form and sign his name. "Title" refers to type of specialty, such as "general medicine", "orthopedics", etc.

General medical, general surgical, or routine physical examinations do not include the sections on EENT. Conditions relative to these systems will require specialist examinations. Height, weight, general appearance, nutrition, muscular development, carriage, posture, and gait should be recorded.

Examiners should constantly bear in mind that they are communicating on paper the results of their examinations to other physicians in the VA, who will not see the veteran.

Experience has shown that x-ray and laboratory work should be reported for the benefit of the clinician at the time of his examination. There should be definite coordination of all reports. The unit may require more than one visit by the veteran to satisfy this standard.

EXAMINATION FOR PSYCHONEUROSIS

A recent VA bulletin states:

"In these cases the examiner should record the veteran's complaints and subjective symptoms separately from the examiner's objective findings, observations and analysis of the case. A study of the longitudinal view of the case should be made. The examiner should note any changes in behaviour pattern attributable to the disease, or their absence, and report on these or their absence. In any case where it has been established that the veteran suffered from a psychoneurosis of combat origin, a change of diagnosis to one reflecting psychopathic personality should not be proposed without full consideration of the veteran's combat experience and effects thereof. Where any veteran with combat experience has manifested symptomatology initially classified as combat fatigue, exhaustion, or under any other of a number of special terms, a subsequent reclassification as psychopathic personality should not be made or continued without the same full consideration. By proper direction of his questions, as to time and circumstances of onset, the examiner should ensure that these become a part of the report of examination."

CHANGE OF DIAGNOSIS

The bulletin states: "In making an examination the examiner should familiarize himself with all earlier diagnosis in the case and assure himself that changes are fully explained and justified. The examiner should endeavor as far as possible to return a correct diagnosis on initial examination by the VA, as well as on subsequent examinations. Particular care is necessary when there are combinations of symptoms in part referable to organic diseases and in part referable to psychoneurotic reactions. Conference of examiners is usually advisable under these circumstances to determine whether one diagnosis may cover all the symptoms or for the allocation of the symptoms to the separate diagnoses."

VETERAN'S COMPLAINT

The examinations requested by the Rating Board will sometimes appear inadequate in the face of complaints registered by the veteran. It must be kept in mind that only the claim made by the veteran has been considered by the Rating Board. New symptoms coming into the mind of the veteran should not be considered, except to the extent of their being covered in the history and examination. Making recommendations in the report for additional special study with reference to conditions irrelevant to the claim is not suggested.

DISCUSSION OF CLAIM WITH VETERAN

Physicians should not discuss the veteran's defects or tell him the amount of disability or pension he should receive. A physician, who had examined a veteran prior to his filing a claim, is not permitted to make the claim examination.

PAYMENT TO PHYSICIANS

A simplified billing procedure has been devised. The IBM form sent with the authorization will show a list of the examinations, alongside of which a space is provided for each physician to record his name and code number. No other billing procedure will be required for either the physician or the unit.

The Plan in each county will assign code numbers for the participating physicians, forwarding to the Liaison Officer a duplicate copy, showing also the address of each physician. Each Plan has been informed regarding the starting code number for its physician. As new physicians enter the Plan, supplementary lists will be sent to the Liaison Officer.

CLERICAL DETAILS

The authorization issued by VA will be the sole guide as to the type of examination desired. The listing of the examinations on the IBM sheet may sometimes be incorrect and should be corrected by the Unit Clerk. The original IBM sheet will be returned to the Liaison Officer when the report of the physical examinations is completed. The Unit should retain the VA authorization and duplicate of the IBM sheet.

Examinations are to be completed and reports rendered within thirty days.

Date of authorization should be recorded in the upper right hand corner of the Report of Examination (Form 2545).

The unit clerk will notify the veteran when he should appear for his examination. The clerk will record the date on which the veteran was notified, in the space provided on the IBM sheet.

FAILURE OF VETERAN TO APPEAR

Every effort should be made to get the veteran in for his examinations. A second notice within a week is suggested when the veteran does not respond. If the veteran does not answer in any way within two weeks, the unit clerk will return the VA authorization and the IBM form to the Liaison Officer with a letter addressed to the VA, stating:

"Named veteran was notified on (date) to appear for pension examination at (hospital unit), but to date has not replied by telephone, letter or in person, and authorization is being returned for further action."

INDUSTRIAL HISTORY

Page one of the Physical Examination Report must be completed in detail, particularly with reference to the industrial history. It is suggested that a mimeographed copy of page one be sent to the veteran with his letter of notification, asking him to complete the form so that when he arrives at the Unit, great loss of time will not be involved in questioning him to obtain the answers to the questions.

Section five on page one referring to his current examination, may be omitted on the mimeographed copy.

The details relative to the medical and industrial history in section eight on page one should be broken down in the mimeographed copy to facilitate the veteran's supplying the information.

BOOKKEEPING

The IBM Service Bureau will set up records to permit billing VA for each Plan. The original IBM sheet returned by the Unit to the Liaison Officer will show the names and code numbers of the physicians who have done the work. This information will go to IBM to set up the physicians' accounts. After payment by VA to the Plan, the Plan will notify the Liaison Officer. IBM will then be requested to make the voucher checks for the physicians. These will be sent in bulk to the Plan for signatures and distribution to the physicians.

The Plan will receive from the Liaison Officer a copy of the bill submitted to VA and a copy of the physicians' vouchers. The mathematics involved in the remainder of the bookkeeping will be done by the Plan.

The Liaison Officer will maintain a file of all cases released to the Plans through him by VA. The number appearing on the authorization and the IBM sheet is his filing reference. VA files by date of authorization.

E. T. YORKE, M.D.,
Liaison Officer.

AUTHORIZATIONS NEEDED FOR DIAGNOSTIC SURVEYS

The Veterans Administration has cleared up the lag on issue of authorizations for the treatment of veterans. It is necessary to inform physicians not to procede any longer with diagnostic surveys of any kind without first receiving authorization from VA. Whenever a condition requiring diagnostic survey is an emergency, physicians should telephone VA at MA 3-6800, Extension 440.

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Chairman Nutrition Committee

1. *I have had two cases of hemorrhagic disease of the newborn. Can treatment be given to the mother to prevent this?*

   Yes. Give the pregnant patient menadione (vitamin K), two milligrams daily during the last week of pregnancy. This will also eliminate the bleeding tendency associated with obstructive jaundice in patients who are ready for surgery.

2. *Is adrenalin contraindicated in diabetes?*

   No, but it should be used judiciously since adrenalin may cause an elevation of the blood sugar and sugar in the urine through its effect upon the liver.

3. *When and how should fluorine be used on teeth?*

   Use a two per cent solution topically once a week up to four years of age (before the enamel is established). After this age, use five topical applications per year as a prophylaxis.

4. *If left-over turkey or meat is reheated, what is the loss in vitamins?*

   Thiamin, which is the important vitamin present, is not lost in reheating.

5. *Patients on reducing diets often complain of aching and stabbing pains in the feet. How can this symptom be alleviated?*

   One of two things may cause this: amphetamine sulfate or a deficiency of niacin. If no amphetamine is being given, prescribe niacinamide, 150 milligrams daily.

6. *From a clinical point of view which is more nutritious, milk fats or vegetable fats?*

   They have the same food values.

7. *I have a patient who has gout and every time I give him vitamin B-complex his gout becomes aggravated. Why?*

   Vitamin B-complex contains purins in variable amounts depending on its source and refinement. Beef liver contains 233 milligrams of purine bodies per 100 milligrams of liver. "Bemax" contains up to 75 milligrams of purine per 100 grams. Yeast, which is a splendid source of B-complex, contains an insignificant amount of purine. Hence vitamin B preparations which contain sizeable amounts of purines should not be given to patients with gout.

OBITUARIES

DR. WILLIAM H. CARPENTER

Dr. William Howard Carpenter of Woodbury, medical director of the Girard Life Insurance Company of Philadelphia, died at his home on December 14, 1946. Born in Salem, N. J., Dr. Carpenter was graduated from the medical school of the University of Pennsylvania in 1892. His first office was in Salem, but he left the state during World War I to serve as a captain in the medical corps, and after his discharge moved to Woodbury where he resided until the day of his death. He has served as a director of the Salem National Bank, and secretary of the Salem *Standard*. Dr. Carpenter has been an active member of the Gloucester County Medical Society for the past quarter of a century and has long been respected and honored as one of South Jersey's senior practitioners.

DR. HARRY JARMULOWSKY

Dr. Harry Jarmulowsky, a Paterson practitioner since 1917, died at the age of 69 on January 27, 1947. He was graduated from the medical school of Columbia University in 1906 and moved to Paterson after a brief period of practice in New York City. He died at his home at 181 East 33d Street, Paterson.

NEW ANESTHESIA SOCIETY

Anouncement is made of the organization of the New Jersey Society of Anestheologists. The president is William J. Gleeson, M.D., of Jersey City, and the secretary is Abraham L. Dear, M.D., 23 Synott place, Newark. All physicians in this state interested in anesthesia are invited to participate and to obtain further information on the Society from Dr. Dear.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

DIPHTHERIA INCREASING

Diphtheria increased in prevalence in New Jersey during 1946 according to reports received by the State Department of Health. In reported cases the increase during the year was 120; by ratio, the increase was eighty per cent. Diphtheria had been decreasing each year since 1930. Whether the increase in 1946 resulted from a more virulent infection or otherwise is academic; the practical side is the fact of the increase. Cases were reported from twenty of the twenty-one counties. Counties reporting the largest number of cases were Camden, Hudson and Middlesex.

Toxoid as a preventive of diphtheria has proved its value. It may be obtained by any physician without charge at any of the 60 distributing stations located about the state. Its use on young children is urged. A booster dose at the time the child enters school is also most desirable. Diphtheria is preventable.

VACCINE DEATHS

The State Department of Health received a report of the death on December 1, 1946, of a male, white child, eighteen months old, 28 hours after subcutaneous injection of influenza virus vaccine. Death was reported as due to "acute hemorrhagic encephalitis anaphylactic shock".

The Health Department joins the manufacturers of influenza virus vaccines in cautioning against the use of this material in young individuals.

PENICILLIN IN SYPHILIS

Complaints are being received from patients about the pain caused by the frequent injections of penicillin sodium in the treatment of syphilis. This discourages others from accepting the state plan for hospitalization and penicillin treatment of syphilitic patients. Following are a few suggestions for reducing pain to a minimum:

Site of injection—The choice is the *upper outer quadrant* of the gluteal region. This area is less sensitive to the needle prick and avoids the large bloodvessel and nerves which may be injured in the other quadrants. Other good areas are: deltoid regions of upper arms, upper back between the shoulder blades and the lower quadrants of the abdomen.

Amount of drug—It is preferable to use a small amount of diluent; that is, dissolve 40,000 units of penicillin in one cubic centimeter of fluid.

Needle—No longer is it necessary to resort to long, thick needles. A 5/8 or 3/4 inch needle of 25 guage is adequate. Use a quick thrust of the needle when inserting it into the tissues.

Psychologic factors—A feeling of guilt and fear may make the syphilitic patient unusually sensitive about the attitude of hospital personnel. Many patients dread "getting the needle" every two hours. A sympathetic, non-judgemental attitude on the part of the doctor and nurse can help to overcome these factors which determine so largely whether or not the patient will cooperate in bringing other infected persons to treatment.

NEW JERSEY DIABETES ASSOCIATION

Announcement is made of the organization of a New Jersey Diabetes Association. Dr. Benjamin Saslow of Newark is chairman of the organizing committee. The new society is affiliated with the American Diabetes Association, and like the latter aims at disseminating knowledge of diabetes, educating the laity, cooperating with associated groups and conducting clinical, experimental and demographic studies of diabetes. The participation of interested physicians is welcome and further information is obtained from Dr. Saslow at 102 Shanley Avenue, Newark 8, N. J.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held on January 10, at the Traymore Hotel. DR. LAWRENCE WILSON, president, introduced the guest speaker, HUGO ROESLER, M.D., Associate Professor of Cardiology at Temple University. Dr. Roesler spoke on *Angina Pectoris and Cardiac Infarction.*

Of the many causes of angina pectoris, Dr. Roesler stressed stenosis of the coronary arteries as the most outstanding one. He reviewed the other causes. To avoid possible clinical errors, he stated that one should always keep in mind the possibility of atypical angina. Under management, the standard methods of treatment were mentioned with the use of nitroglycerine still at the top of the list for the relief of pain.

The clinical recognition of cardiac infarction is imperative to ascertain the prognosis, and to treat the case properly. In his opinion, the prognosis is usually unfavorable.

Dr. Roesler concluded his paper with excellent slide presentation of varied electrocardiographs. Many of the members present entered the lengthy discussion led by DR. PHILIP MARVEL. The president then thanked the speaker on behalf of the society.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society*, held at Bergen Pines Hospital, Oradell, N. J., on the evening of January 14, 1947, was called to order by the president, DR. A. W. CLOUD, at 9:15 p. m.

The minutes of the meeting of December 10 were accepted as read. The minutes of the executive committee meeting of December 17 were approved as published in the *Bulletin.*

It was announced by President Cloud, that a meeting of the Bergen County Council of Social Agencies will be held on February 3. MR. FERBER will speak on the *Medical Center Plan at Bergen Pines.* This will be followed by an open forum.

Dr. Cloud introduced the speaker of the evening, DR. FRANK B. BERRY, Surgical Director, Chest Service, Bellevue Hospital, whose topic was *Carcinoma of the Lung.* He outlined his experience in the treatment of pulmonary carcinoma and pointed out that at this time the only hope for the surgeon in raising the woefully low percentage of surgical cures lay in obtaining cases at the earliest possible moment. When physical examination, history, x-ray, and sputum examination are positive, it is nearly always, in Dr. Berry's opinion, too late for surgical interference, except for palliative treatment. He also illustrated several of his cases by the use of lantern slides.

BURLINGTON COUNTY

T. B. Dickson, Reporter

The *Burlington County Medical Society* held its monthly meeting at the Riverton Country Club on December 12, 1946.

Guest speaker was DR. NEWLIN F. PAXSON, Professor of Obstetrics at Hahnemann Medical College. He was introduced by DR. EDWARD HALDEMAN. Dr. Paxson spoke on *Gynecologic Treatment in Office Practice.* He advised that the lay-out be simple and disapproved of an office full of complicated apparatus. The most important point is a good history. Dr. Paxson told of the causes of leucorrhea, vaginal bleeding and dysmenorrhea. After describing these conditions, he indicated what the treatment should be in each case. The lecture was illustrated with slides which showed the pathology and technics. It was a profitable evening for all the members.

DR. JOSEPH KUDER, chairman of the Veterans' Liaison Committee, stated that a veterans' clinic was not needed in Burlington as there are only about 525 veterans in the county who are applying for pension or compensation.

A memorial to Dr. Edgar J. Haines was presented by DR. HOWARD HORNBERGER.

New members to the County Society are Dr. John W. Manning of Pemberton; Dr. J. Arthur Steitz of Mount Holly, and Dr. Richard T. Buckley, who transferred from Mercer County and is in Maple Shade.

The January meeting of the *Burlington County Medical Society* was held at the Riverton Country Club on January 9, 1947.

DR. WILLIAM BRAY, the president, introduced the principal speaker DR. EDWIN N. MURRAY who spoke on *Coronary Artery Disease—Its Diagnosis and Treatment.* He began by stating that the classification of heart disease is now based on etiology rather than anatomy. In detail he portrayed the symptoms found in passive congestive heart failure; disturbance of rhythm and conduction; angina of effort and myocardial infarction. Dr. Murray then took each subject and discussed its treatment and the efficacy of the drugs to be used. The talk was informative and well presented.

Dr. Bray announced that a cancer clinic will be opened soon at the Burlington County Hospital and will function two days a week. Zurbrugg Memorial Hospital has no regular cancer clinic.

Representatives of the Woman's Auxiliary of the county society led by Mrs. Anthony Ziccardi, the president, were present. Mrs. Ziccardi outlined what the Auxiliary had planned to accomplish. A committee headed by DR. DEAN H. LEFAVOR was appointed by Dr. Bray to cooperate with the Auxiliary.

CAMDEN COUNTY

The regular monthly meeting of the *Camden County Medical Society* was held at the Camden City Dispensary on January 7, 1947. The meeting was called to order by DR. HENRY B. DECKER at 9 p. m.

The scientific program consisted of case reports as follows: *Coronary Occlusion* by DR. HAROLD K. EYNON, *Pregnancy complicated by Ascites* by DR. ROBERT BOWEN, *Maternal Obstetrical Palsies* by DR. F. J. HUGHES and DR. E. A. DENBO, *Myocardial Infarction* by DR. E. N. MURRAY. The cases were discussed by Dr. Goldstein, Dr. Fred Becker and Dr. Wesley Jack. The Society voted thanks to the presenters for their excellent reports.

DR. W. T. SNAGG, chairman of the Veterans Liaison Committee, read the reply of the Veterans' Administration to the specific proposals of the County Society for establishing an examination clinic as authorized at the last meeting.

DR. T. B. LEE moved that the present By-Laws of the County Society be adopted as the By-Laws of the Incorporated Society. This was unanimously passed when seconded by DR. EDWIN R. RISTINE. A motion was also passed authorizing the president and secretary to sign the deed for the sale of the Kaighn Avenue property.

Dr. Ristine announced that the Executive Committee had authorized expenditure of $500.00 for painting and for plumbing repairs to the Dispensary Building.

The applications of Drs. S. P. Bernell, N. K. Boudwin, D. C. Campbell, M. B. Clark, J. V. Connell, L. J. Hammett, A. E. Hirshorn, R. E. Imhoff, T. M. Kain, Jr., H. P Shipps, and J. L. Witkowski were approved by the Censors and Membership Committee. Their admission was moved seconded and passed.

The censors and membership committee reported that Drs. S. I. Adam and S. Garrison, Jr., were not eligible for membership because they do not reside and practice in the county. Dr. Mazur, who applied for membership in October, reported that he had moved to Riverton and had joined the Burlington County Society.

The amendment to the Constitution read last month was reread and adopted by vote of the Society.

CAPE MAY COUNTY

C. W. Way, M.D., Reporter

A meeting of the *Cape May County Medical Society* was held at Fred's Restaurant, Cape May Court House on January 21, with the president, J. S. D. EISENHOWER presiding.

DR. ALDRICH C. CROWE, F.A.C.P., past president of the Cape May County Medical Society, and now chairman of the Board of Trustees of The Medical Society of New Jersey, was endorsed for the position of second vice-president of the State Medical Society.

A motion was made that the delegates of the Cape May County Medical Society suggest that legislation be initiated to empower the State Board of Medical Examiners to prevent any other than doctors of medicine of accredited medical schools to use the M.D. degree. The president instructed the Program Committee to prepare a scientific program for the next meeting to be held at Fred's Restaurant on Tuesday evening, March 4. A splendid midnight supper was served after the meeting.

CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

Thirty-one members of the *Cumberland County Medical Society* met for a regular meeting at Richards Farms, Rainbow Lake, Vineland, February 11, 1947, at 2:30 p. m. The meeting was in charge of the president DR. ALBERT KUMP.

Dr. L. E. Rosiello has been admitted to our society by transfer from Bronx County.

A lengthy discussion was held concerning the qualifications for coroner in our county. It was resolved that duly licensed physicians be candidates on the political slates. A committee was appointed from the society to meet with the steering committee of both political parties.

Inasmuch as Cumberland is one of the few counties requiring a one years residence before applying for membership to the Society an amendment was proposed to change this rule. This important matter will be brought to vote at the next regular meeting.

DR. RALPH HAND, Orthopedic Surgeon at Jefferson Hospital, spoke to us on hip injuries. He does not favor the sand bag immobilization of the past and feels that early operation with the aid of pins and nails, for intertrocanteric and neck fractures of the femur was the method of choice. He illustrated his talk with lantern slides.

Dinner was served after adjourment of the meeting.

ESSEX COUNTY

Felix J. Di Fino, M.D., Reporter

The use of chemicals and antibiotics in the treatment of surgical infections was discussed at the regular monthly meeting of the *Essex County Medical Society,* held at 9:00 p. m., on Thursday, January 9, 1947, at the Academy of Medicine, 91 Lincoln Park, Newark, N. J. The president, DR. T. W. HARVEY, who presided at the meeting, introduced the speaker, DR. FRANK L. MELENEY, associate professor of clinical surgery at Columbia University Medical School.

In his lecture, Dr. Meleney spoke of the development of a penicillin-like substance which he said promises to surpass penicillin itself. The matter, called bacitracin prepared from a spore-producing bacillus discovered in the leg of a girl about four years ago, attacks the same general group of pathologic organisms as does penicillin, but is less subject to counteraction. This new drug is more easily absorbed into the body and stays in the body longer. Dr. Meleney also stated that even though it is difficult to produce commercially, he uses bacitracin exclusively in the treatment of boils, carbuncles, surface and deep abscesses.

The following applicants were elected to membership:

For Reinstatement: A. Allan Cott, Newark, and Ephraim Horland, Newark.

For Transfer—Active: Harold Somberg.

For Associate: Kenneth E. Crater, Bloomfield; Otto Gambacorta, Newark; S. Jerome Greenfield, East Orange; Thomas L. Pasquale, Orange, and Franklin Ott, in service; Maximilian Perlman, Newark; Francis R. Sandford, Caldwell; Leo H. Siegel Newark; John A. Strazza, Jr., Bloomfield; Adrian Taterka, Newark; William E. Wakeley, Jr., East Orange, and Herbert H. Whigham, Montclair.

The regular monthly meeting of the *Essex County Medical Society,* held at the Academy of Medicine (91 Lincoln Park) Newark, on February 13, 1947, was called to order by the president, Dr. Thomas W. Harvey, at 9:00 p. m. Principal speaker was Dr. Louis F. Bishop, Jr., Assistant Clinical Professor of Medicne, New York University Medical College, New York, who spoke on the *Management of the Cardiac Patient.*

Dr. Bishop discussed the treatment of cardiac diseases from the standpoint of the general practitioner and offered his interested audience some timely, philosophical ideas which they could easily put to use in their every day practices.

At this meeting, the following applicants were elected to membership:

For Reinstatement: Armand A. Picardi, Newark.

For Transfer-Active: Ferdinand A. Roth, East Orange, and Victor Rudomanski, Kearny.

For Active: Joseph C. Borrus, Newark, and Nathan Zukerberg, Newark.

For Associate: Sylvia F. Becker, Frank D. Bellucci, Benjamin R. Blasi, Clifford B. Blasi, Louis G. Cacchioli, Bernard Chromow, Phillip E. Gear, Bernard German, Stanley J. Goodman, and Elbert H. Pogue all of Newark, and Seymour Taffet, Bloomfield, and Leonard J. Vernon, Orange.

GLOUCESTER COUNTY

David R. Brewer, M.D., Reporter

The regular meeting of the *Gloucester County Medical Society* was held on January 16, 1947, at the Woodbury Country Club with Dr. Louis Collins presiding.

Dr. Wendell Burkett, chairman of the legislative committee described the Taft bill as a federal health bill which would create a Department of Health and would give aid to the states.

The Public Relations committee delegated Dr. C. A. Bowersox to speak at the county meeting of the Visiting Nurse Association on January 21. His topic will be *The Heart Problem.*

Dr. Hilton Read of Atlantic City has resigned as delegate to the American Medical Association from the Fifth district. The state delegate, Dr. B. A. Livengood was authorized to nominate Dr. R. K. Hollenshed for this position.

Dr. J. Harris Underwood announced that all bills for expenses in the Cancer Control Clinic must be submitted to the chairman of the Committee.

The speaker of the evening was Dr. Louis Clerf, professor of Broncho-Esophagoscopy at Jefferson Medical College. Dr. Clerf gave an interesting lecture on *Diseases of the Chest.*

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting, at which Dr. C. E. McNenney presided, at the Masonic Club in Jersey City, on January 7, 1947.

The following recommendations of the executive committee were acted upon favorably:

1. That honorary membership be conferred upon Dr. Wallace Pyle of Jersey City.
2. That the prewar custom of an annual dinner be revived this year; and that those who served in the armed forces be invited as guests.

The secretary read a communication from the Joint Committee on Professional Relations of The Medical Society of New Jersey and the New Jersey Pharmaceutical Association, in which it was suggested that in view of the excellent progress made by the Joint Committee at a state level, the program be expanded to include cooperation between organized medicine and pharmacy at the county level, where some of the important problems confronting both professions can be considered to better advantage.

The following applicants were elected to membership: Dr. Berthold Salzmann. Dr. Henry P. Wager, Dr. Arthur Zampella and Dr. Henry D. Chieffo, all of Jersey City; Dr. Mario E. Sciorsci of Hoboken; Dr. Carmine J. Masiello of Union City; and Dr. Irving Zuckerberg of Bayonne.

Guest speaker of the evening was Dr. Ashley W. Oughterson, Medical Director of The American Cancer Society, who discussed the *Medical Effects of the Atomic Bomb on Japan.* Dr. Oughterson described his personal observations when, as a member of the army medical unit assigned to study conditions in the bombed area, he visited Japan shortly after the bombing of Hiroshima and Nagasaki. He used colored slides to augment his vivid description of the immediate effects of the bomb on human bodies as well as on the terrain, and also to illustrate radiation effects which became apparent after an interval of about two weeks. Dr. Oughterson received a rising vote of thanks for his interesting and unusual presentation.

Hudson County Medical Society held its regular monthly meeting on February 4, 1947, at the Masonic Club in Jersey City. Dr. C. E. McNenney presided.

Dr. John D. Walsh of Hoboken and Dr. William J. McKeever of Jersey City were elected to membership.

Guest speaker was Dr. Virginia Kneeland Frantz Assistant Professor of Surgery at Columbia University College of Physicians and Surgeons, whose subject was *Hemostasis with Absorbable Substances.* Dr. Frantz included in her presentation an exceptionally interesting and instructive motion film, directed by herself, that showed her own experimental work with oxidized cellulose— and also the use of this hemostatic agent in neurosurgery, as well as in bone and abdominal surgery. The other hemostatics, fibrin foam and gelatin sponge, with and without thrombin, were included in this unique presentation. Drs. Waters, Judy, Butler and H. B. Schwartz were discussants.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

Under the chairmanship of DR. JAMES PREGNALL, president, the *Monmouth County Medical Society* held its regular monthly meeting at the Monmouth Memorial Hospital in Long Branch. DR. LOUIS ALBRIGHT introduced the guest speaker, DR. CLARENCE E. DE LA CHAPELLE, professor of Clinical Medicine at New York University. Dr. Chapelle discussed some diagnostic and therapeutic problems arising during the *management of cardiovascular disease.* In discussing coronary arterial disease, he said that the diagnosis was made more frequently than the condition existed. After discussing the symptoms of coronary arterial disease, Dr. Chapelle gave the differential diagnosis emphasizing those conditions most often confused with coronary disease. More important in the treatment of this condition is a change in the mode of life and general hygiene than any or all the drugs available.

Dr. Chapelle closed his discussion with the subject of congenital heart disease. Those conditions amenable to operation were outlined and the latest operations mentioned. Discussion was opened by DR. F. J. ALTSCHUL. Other members also presented questions. These were answered by Dr. Chapelle.

The business session was opened with a report of the executive committee. It was announced that the Women's Auxiliary are giving a ball, the proceeds of which are to be used to buy equipment for a premature unit at the Monmouth Memorial Hospital, Long Branch.

The following were elected to full membership: Dr. Irving Baer, Dr. Irving Gruber, Dr. William Koch, Dr. Elias Long, Dr. Robert McCurdy, Dr. Norman Nathanson, Dr. Leo Rocco and Dr. Victor Siegel. Dr. Harold Pieper received a transfer of membership from the Tulsa County (Oklahoma) Medical Society. Dr. Paine, Dr. Adler, Dr. Noles, Dr. Schmaier and Dr. Wynder were elected to associate membership.

DR. VICTOR KNAPP moved that an amendment be made to the constitution requiring that a quorum be 20 per cent of the membership. At present a quorum is only 10 per cent. It was seconded by Dr. Parry. This amendment is to be submitted in writing.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on January 21, 1947, at the Administration Building, Paterson, with DR. HARRY WOLFSON, presiding.

Following physicians were unanimously elected to membership: Dr. Harry Golish and Dr. Leo J. Barone of Paterson as active members; Dr. Philip Snell, Dr. Bernard Pinck of Passaic; Dr. Alex Hochman, Dr. Norbert Beim and Dr. Charles A. Nuzzolo of Paterson as associate members.

Attention was called to the fact that under the new contract between the Veterans Administration and the Medical Society, all members are eligible to treat veterans.

A constructive report of the Committee on Child and School Health, prepared by DR. ISRAEL J. WOLF, was read and discussed.

DR. LEWIS DUNBAR STEVENSON, Associate Professor of Clinical Medicine and Neuropathology at Cornell University Medical College, introduced by Dr. Wolfson as the speaker of the evening. Dr. Stevenson presented an informal discussion of *Common Neuropsychiatric Disorders and Their Treatment.* He cited etiologic factors in the production of headaches, epilepsy, Parkinson's and Meniere's syndromes and discussed the treatment of these conditions.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

Regular meeting of the *Warren County Medical Society* was held in Phillipsburg, on January 21, with 18 members and guests present. In the absence of the president, DR. P. KASSOW, the meeting was called to order by the president elect, DR. W. BOQUIST.

The new by-laws were discussed and laid on the table till the next regular meeting.

DR. VARNEY reported that the Hunterdon-Warren County plan for the care of veterans had been signed by the trustees and had been forwarded to Washington.

Dr. Sandor Szittyka of Phillipsburg and Dr. Francis Martin of Belvidere applied for membership in the society. The applications were referred to the censors who are to report at the next meeting.

Drs. Drake, Humbert and Baldauf were appointed a committee to meet with the trustees of Warren Hospital to discuss the necessity of opening an isolation ward.

The meeting adjourned to the dining room, where a turkey dinner was served to the members of the Society and the Ladies Auxiliary.

NORTH JERSEY MEDICAL SOCIETY

H. F. Inge, M.D., Secretary

On January 19, 1947, the *North Jersey Medical Society* gave a testimonial dinner to three of its members who were recently elected to fellowship in the American College of Surgeons. DOCTORS ALTON BYTHEWOOD, EUCLID GHEE and MERVIN JONES are the first New Jersey physicians of the Negro race to win the F.A.C.S. title. DR. WALTER G. ALEXANDER was toastmaster, and he was introduced by DR. WILLIAM H. BROWN, president of the North Jersey Medical Society.

Speakers included DR. FRANK G. SCAMMEL, president of The Medical Society of New Jersey, and DR. HARROLD A. MURRAY, president-elect of the Essex County Medical Society, who brought the greetings of their respective organizations. DR. CHARLES A. SCHLICHTER of Elizabeth spoke as did MRS. C. E. LEWIS, president of the Ladies Auxiliary of the North Jersey Medical Society. Other speakers were DR. HENRY A. DAVIDSON, Editor of *The Journal of the Medical Society of New Jersey,* DR. JOHN KINNEY, founder of the Newark Community Hospital, and DR. L. GREELY BROWN chief of staff at the Newark Community Hospital.

Principal address was made by DR. JOHN S. TURNER, president emeritus of the Douglass Hospital in Philadelphia. The three honored guests then delivered short responses.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. F. G. Wandall, Clayton, N. J.

The word "Convention", does not adequately describe the intricate pattern in the overall picture of the Annual Meeting of the Woman's Auxiliary to the Medical Society, which occurs this year on April 22, 23 and 24th.

Of course there must be the serious matter of putting our house in order; straightening out the details in all phases of Auxiliary work. These include reports of the state chairmen, and component counties, showing the accomplishments and growth of our organization. It also affords the Executive Board an opportunity to acknowledge publicly the efforts expended by all the Auxiliary members, in helping to bring about these final accomplishments.

Many interesting and relaxing features are interspersed in the business sessions. Atlantic City is an attraction in itself. The unique roller chair rides, and the shops along the Boardwalk, for which this resort is famous, afford wonderful enjoyment. Within the Convention, at the Haddon Hall, there will be an informal "Get-to-gether", between 3:30 and 4:30, Tuesday afternoon, in the solarium. This will give new members an opportunity to become acquainted, and others a chance to renew past friendships. The luncheon on Wednesday is always a gala affair. The music, the flowers and gay conversation all make for a very carefree gathering indeed.

The Mennen cocktail hour, on Wednesday afternoon, will appeal to many physicians and their wives. This will precede the highlight of the Convention. The Medical Society has gone to no end of effort to be sure the annual dinner on Wednesday night, will appeal to every one. Those who are there for the day, need have no worries about formal attire. The party will be informal. There will be dancing, and entertainment. And Alfred E. Driscoll, Governor of New Jersey, will be the speaker of the evening.

So—let first things come first. Attend the Convention, with the desire not to miss a single feature. Not even the general session of your Auxiliary.

ARCHIVES

Mrs. C. Chester Chianese, Chairman

"To build on the foundation of yesterday
With the tools of today
The better medical world of tomorrow."

The origin, aims and achievements of The Woman's Auxiliary to The Medical Society of New Jersey are recorded for future reference by safe-keeping all valuable documents, written accounts of facts and events.

To assist the county auxiliary archives committee chairman to fulfill her duties of office, the following suggestions are listed:

1. File old minutes, annual reports and important letters.
2. Keep a photograph album of presidents with names of officers during each administration.
3. File the annual history; append a necrology.
4. Save copies of county society medical histories.
5. File scrapbooks, programs, pamphlets, sample stationery, etc.
6. Discard unnecessary material. Store archives in a steel file.
7. Project for this year: frame and nameplate past presidents portraits for your meeting room.

ANNUAL MEETING OF A.M.A. AUXILIARY

Haddon Hall will be the headquarters for the Annual Meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, New Jersey, June 9 to 13, 1947.

Requests for reservations should be sent immediately to Dr. Robert A. Bradley, Subcommittee on Hotels, 16 Central Pier, Atlantic City, New Jersey.

AUXILIARY REPORTS

Camden County

Mrs. Wilmer F. Burns
Chairman, Press and Publicity

The annual legislative meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held February 4, 1947, at the home of Mrs. A. Haines Lippincott in Camden.

Mrs. Ralph K. Bush, legislative chairman, introduced the speaker, Dr. Thomas K. Lewis, who is chairman of the Board of the Medical Surgical Plan. *Trends in Legislation* were explained to the group by Dr. Lewis who recommended a voluntary medical and hospital insurance rather than socialized or centralized medicine. The former will protect the quality of the practise of medicine and the health and welfare of the American public.

Mr. Fred Homer entertained with three vocal selections accompanied by Mrs. Homer.

After the program, Mrs. A. Lincoln Sherk, president, conducted a brief business meeting during which the honored guests were introduced. These included: Mrs. Frederick G. Wandall, president of the Woman's Auxiliary to The Medical Society of New Jersey and Mrs. L. Mancusi-Ungaro, president-elect of the same organization, Mrs. A. J. Casselman, Mrs. A. Haines Lippincott, Mrs. David B. Allman, Mrs. O. R. Carlander, Mrs. Chester I. Ulmer, Mrs. Thomas P. McConaghy, Mrs. Banks S. Baker and Mrs. Thomas H. McGlade all of whom are members of the Executive Board of the State Auxiliary.

Six new members were accepted at this meeting making a total enrollment of 129. It was unanimously voted to make Mrs. John E. Van Sciver and Mrs. W. H. Pratt honorary members of the Auxiliary. Delegates for the A.M.A. Convention were elected at this time.

At the conclusion of the meeting tea was served by the Hostesses with Mrs. Joseph E. Roberts and Mrs. Arthur J. Casselman pouring.

Essex County

Mrs. Ames L. Filippone,
Chairman, Press and Publicity

Mrs. Frank S. Forte presided at the regular monthly meeting of the *Woman's Auxiliary to the Essex County Medical Society* on January 27, at the Academy of Medicine in Newark. An outstanding report was given by Mrs. Paul Aszody, chairman of the Cancer Committee. She described how groups had been organized all over Newark to make bandages and dressings for cancer sufferers in the hospitals, clinics and dispensaries. Our members who have volunteered for this work supervise their respective groups, meeting once a week for a period of two hours. More workers are needed. Let us all help in this tremendous job thereby demonstrating our deep interest in the public welfare of our city.

After other committee reports, Mrs. Don Caldwell, program chairman, introduced the speaker of the day, Karl H. Platzer, Ph.D., consulting psychologist. Dr. Platzer spoke on the *Relationship Between Physician and Psychologist*. He stressed the relation between mental health and physical health. He described at length the various methods of testing individuals needing help. "Psychologic factors often are found in cases handled by cardiac specialists, internists and neurologists," he said. "Patients with psychosomatic disorders, such as peptic ulcers, mucous colitis, chronic sinusitis, headaches and allergies should have their psychologic structure explored. Many physicians say that from 40 to 60 per cent of their practice is made up of people with emotional disorders. The responsibility for treating patients is, of course, the physician's. The consulting psychologist, by skilled interpretation of tests, helps the physician make and reinforce his diagnosis and plan the therapy."

A very interesting question period followed.

Gloucester County

Mrs. J. F. Hughes, Chairman, Press and Publicity

Mrs. C. A. Bowersox, president, presided at a luncheon and regular business meeting of the *Woman's Auxiliary to the Gloucester County Medical Society* held on Thursday, January 16, at the home of Mrs. P. M. Pegau, Woodbury. Fifteen members were present. Following a delicious luncheon, talks on legislation were given by Mrs. F. G. Wandall, President of the Woman's Auxiliary to the Medical Society of New Jersey, and Mrs. C. I. Ulmer, state chairman of legislation. Mrs. Fred Faux was appointed chairman of the nominating committee.

Hudson County

Mrs. Sidney Chayes,
Press and Publicity Chairman

The *Woman's Auxiliary to the Hudson County Medical Society* met on January 6, in the Jersey City Young Women's Christian Association, Mrs. Edward A. Murphy, president, presiding. Plans were made for the annual "Reciprocity Meeting" to be held in March. Invitations have already been sent out to the many women's clubs and civic organizations in Hudson County.

The president appointed a nominating committee consisting of Mrs. Samuel G. Barishaw, chairman, and Mrs. William Stewart, Mrs. Miles T. Long, Mrs. Carl Tannert and Mrs. Louis Norwich. When the meeting adjourned, Mrs. William Gleeson, program chairman, introduced Miss Elise Cane, whose topic was *Rare China*. She exhibited some of the famous Copenhagen porcelain dated back to 1779. One pattern was named the Queen Juliana, another the Jubilee; this had been presented to the late King George and to Queen Mary. It was a gift of the people of Denmark on their anniversary. Social hour followed with Mrs. Harry Perlberg at the tea table and Mrs. Francisco Figurelli as hostess.

Mrs. Edward Murphy, president, presided at a regular monthly meeting of the *Woman's Auxiliary*

to the Hudson County Medical Society held at the Young Women's Christian Association, Jersey City, on February 3, 1947.

Two new members, Mrs. A. A. Lepis and Mrs. Henry Chieffo of Jersey City were introduced and welcomed into the Auxiliary.

Mrs. Murphy read a report on the recent state meeting held in Trenton and explained the Ball, Taft and Smith Bill. Cooperation was asked to assist the returning veteran doctor by referring calls to him when the regular physician is not available.

Dr. Foster Kennedy of New York City will be the guest speaker at the March Health Meeting of the Auxiliary to be held at the Young Women's Christian Association. His subject will be *The Organic Background of Mind.* At this meeting the Minnie Friele Memorial Prize will be awarded the Hudson County high school senior writing the best essay on *cancer,* presented in a manner that would tend to stimulate lay interest.

Mrs. William Gleason, program chairman, introduced Mr. Harold Starro from the Pennsylvania Railroad, New York City who spoke on *Railroading.* Moving pictures were shown.

A social hour followed with Mrs. Charles Kelly pouring at the tea table.

Mercer County

Mrs. Joseph R. Burns,
Chairman, Press and Publicity

On Monday, February 10, at 1 o'clock, Mrs. Ernest Purcell, president of the *Women's Auxiliary to the Mercer County Medical Society* was hostess at a luncheon at the Carteret Club. The guest of honor was Mrs. Frederick J. Wandall, President of the Women's Auxiliary to The Medical Society of New Jersey. Mrs. John Kustrup was in charge of arrangements.

Following luncheon, the guest and members adjourned to the Medical Society Building where Mrs. Chester Chianese, program chairman, introduced Mrs. Wandall who discussed the general functions of the Auxiliary and its relation to the Medical Society.

Mrs. Purcell proceded with the monthly meeting. Several new members were presented. The Public Relations Committee reported plans for an interesting meeting early in April. The proposal to have another dinner dance was met with enthusiasm. Ten dollars was the sum voted to be sent to the Infantile Paralysis League. Mrs. A. W. Atkinson, a charter member of the Auxiliary was conferred with an honorary membership. Throughout the meeting, Mrs. Wandall generously gave many helpful suggestions.

Monmouth County

Mrs. Joseph Bossone, Press and Publicity

The *Woman's Auxiliary to the Monmouth County Medical Society* held its monthly luncheon-meeting on January 21, at Paul's Edgewaters in Wanamassa. Mrs. Irving Baer and Mrs. Richard Demaree were hostesses. Mrs. Nathanson presented a report on the State Auxiliary executive board meeting held in Trenton, January 13. A letter was read from the State nominating committee presenting Mrs. Nathanson's name as Director for the State Auxiliary for the coming year, and advising her that she was selected to serve as an alternate from the New Jersey Auxiliary to attend the American Medical Association convention in June in Atlantic City. This will mark the one hundredth anniversary of the A.M.A. A report was given by the committee chairman, Mrs. Bossone, that 100 pairs of bed socks, one hundred boxes of candy, and over one hundred presents donated by the members were wrapped and delivered to Allenwood Hospital.

The Auxiliary decided that a more extensive publicity campaign by the Fitkin and Monmouth Memorial hospitals should be instituted before further plans could be formulated on the campaign for volunteer blood donors.

The organization and membership chairman, Mrs. Stephen Sewell, reported a two hundred per cent increase in membership since 1945.

Announcement was made about the Charity Ball to be held February 14, in Asbury Park. Proceeds will buy equipment for the care of premature babies. Tickets were distributed to the members.

Mrs. Stephen Sewell and Mrs. McGreevey and Mrs. Pregnall were appointed to arrange a cocktail dance to be given by the Auxiliary to the Medical Society.

Passaic County

Mrs. Irving Silverman, Press and Pubilicty

The *Woman's Auxiliary to the Passaic County Medical Society* held its first meeting of the new year on January 20, at the home of Dr. and Mrs. Morris S. Joelson. Mrs. A. G. Markel presided at the business meeting.

Reports were given by the following chairmen: Camp and Hospital, Mrs. A. M. Schultz; Cancer, Mrs. R. J. McDonald; Public Relations, Mrs. P. E. Rauchenbach; Art and Hobbies, Mrs. I. R. Hayman; Hygeia, Mrs. W. A. Morrocco; Bulletin, Mrs. A. C. Meneve.

Mrs. Nicholas Scielzo was appointed chairman of the Widows and Orphans Committee.

Mrs. Peter J. DeBell, program chairman, announced a meeting on prevention of blindness to be presented at the next session which will be held at the home of Dr. and Mrs. Joseph R. Jehl in Clifton.

Mrs. James S. Gallo, membership chairman introduced the following new members into the Auxiliary: Mrs. Joseph Rube, Mrs. Harold Stier, Mrs. J. Varhol, Mrs. A. Siss, Mrs. Peter Pagano, Mrs. T. Stern, Mrs. Thomas Manley, Mrs. L. Carusi, Mrs. J. R. Mabee.

Mrs. Joseph Mott, chairman of the dance held in December in honor of the doctors who had returned from service, gave a complete report, characterizing the function as a hugh success both socially and financially. Mrs. Mott thanked her committee for its splendid cooperation.

Following the business meeting, Mrs. Herbert Hillman of Pine Lakes gave a most informative and enjoyable demonstration on the art of floral arrangement and table decoration.

Volume 44
Number 3

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX March, 1947 No. 3

MANY family physicians with long experience have entertained more than a mere suspicion that individuals belonging to certain families show relatively little resistance to infection with the tubercle bacillus. Now statistical evidence to support such an observation has begun to accumulate. This is of practical importance to both physicians and health officers since a case of tuberculosis in such a family calls for an intensification of all protective measures if spread of the disease within that family is to be prevented.

SPREAD OF TUBERCULOSIS IN FAMILIES OF TUBERCULOUS PATIENTS

A tabulation of the family records of patients with active tuberculosis under the supervision of the Los Angeles County Health Department has uncovered some surprising facts regarding the susceptibility of the members of certain families to the spread of this disease.

The figures show that nearly all of the new cases originate in a comparatively small proportion of the families exposed. These susceptible families deserve earnest study. Preventive measures within them can be successful only as they are directed toward the major elements of spread. What these elements are is still unknown. A family is a complex unit, exhibiting characteristics, traits, and habits that have been in operation for generations. Even though the faults of these families may not be easily corrected, if they can be defined so as to be recognized, they can be made the object of intensive health supervision. If tuberculosis is to be prevented among them, these families must have larger proportions of the tuberculosis prevention budget than is ordinarily allotted to them.

It is characteristic of tuberculosis in Southern California that it is concentrated in a few comparatively congested areas, inhabited chiefly by families in the low income brackets. Here many conditions favor the spread of disease. In planning surveys and applying special preventive measures, tuberculosis attack rates must be given careful consideration. Local surveys in Los Angeles with a house-to-house canvass in poor neighborhoods have detected five times as much active pulmonary tuberculosis as has been found by the same amount of effort expended in other types of surveys. More information about the reasons for spread in the homes where tuberculosis thrives is urgently needed. In these homes, the wage-earner, all other adults and the older children must be examined.

Crowded living quarters constitute a major fault. In spite of improvement, economic conditions must still be considered a factor. Although thousands of these families have moved to modern housing projects and many have been earning big wages, too often they have reverted to old living habits within the new dwellings. These habits have been gradually molded into characteristics that will require long and painstaking efforts to change.

In 1940, the Los Angeles County Health Department analyzed the family records of all the cases of active reinfection type tuberculosis. All cases found in the family within six months of the time that the first case in the family was diagnosed in the clinic were regarded as original cases. Only those detected thereafter were considered new cases whose infection was presumably due to exposure during the period of observation. Contacts with no active tuberculosis were not included in the tabulations unless they had been under observation six months or longer.

There were 506 families with 595 original cases and 1,637 other persons exposed. There

were 135 new active cases developing among these exposed persons, or 8.25 per cent. Of these, four were active nonpulmonary, 45 were active primary and 86 active reinfection type pulmonary tuberculosis. In other words, slightly more than five per cent of the 1,637 contacts developed active reinfection type pulmonary tuberculosis six months or more after the discovery of the first known case in each of the respective families.

This data covers experience during the latter half of the 1931-1940 decade, during the worst years of the depression. Now, four years later, the present active cases have been analyzed, eliminating the families previously tabulated. Unquestionably, there was improvement in the economic status of these families. There was less cause for congestion within the home, and with better living conditions and improved nutrition there should have been less likelihood of the spread of infection. The average number of months of exposure of contacts was also less, because of improvement and extension of the isolation technique. In spite of all this the results show that the justifiable prediction of a lower attack rate would be in error. In 431 families with 1,264 contacts, 60 cases of active reinfection type pulmonary tuberculosis developed among the contacts, or an attack rate of 4.75 per cent. This is very little lower than the rate found in the previous survey.

The hazard in these families with this high attack rate is apparently not only due to the direct spread of the infection, but to other conditions favoring the spread. There must be some inherent fault either in their physical or their mental make-up which makes the members of these families more susceptible than the average person; or there may be contributory domestic habits unchanged by the usual public health education and supervision.

Conditions in other families in similar communities were found to be quite different. The X-ray surveys previously mentioned were carried on in the most congested parts of these same areas, and 22,000 persons examined showed an attack rate of 0.5 per cent. The greater tendency to spread in certain families, in comparison with other families, is demonstrated by the fact that in families having more than one case, even where no positive sputum can be found, there is a high attack rate.

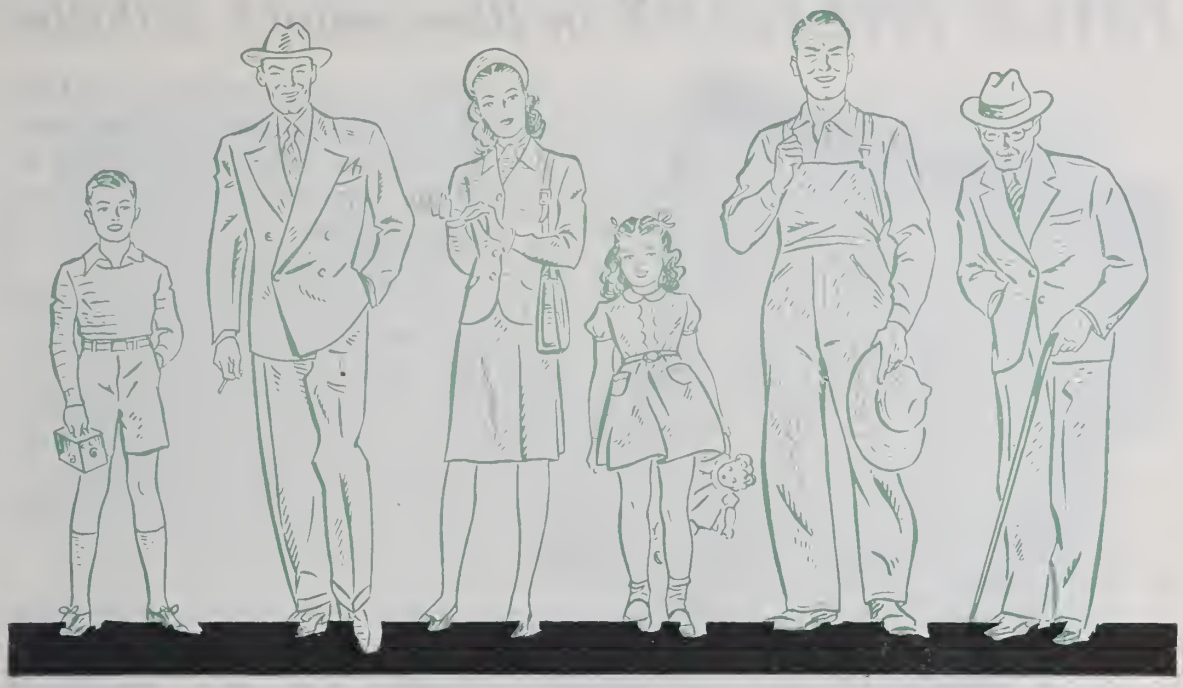
With this high attack rate in certain families, it would seem justifiable to isolate outside of the home every active case occurring in a family with a history of considerable tuberculosis. The effectiveness of such a ruling was shown in a small neighborhood where nine deaths occurred in eighteen months. An arbitrary edict was issued that no active case would be permitted to remain at home in that neighborhood. This stopped the spread and there have been no new cases. In another district, where there were a number of ex-sanatorium, chronic, advanced, communicable cases it was found possible to isolate within the homes with extra assistance. This procedure was found to be effective in stopping the spread of infection. In this type of family isolation is essential. The cases found should not be permitted to remain at home unless considerable material assistance is available and intensive supervision is supplied.

Spread of Tuberculosis in Families of Tuberculous Patients, P. K. Telford, M.D. and Ruth Garten-White, M.D., American Review of Tuberculosis, March, 1946.

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2 Gold does not benefit all patients with rheumatoid arthritis.

3 Gold is not the final answer to the treatment of rheumatoid arthritis.

4 Toxic symptoms may appear at any time during this form of therapy.

5 From 10 to 20 per cent or more of patients who have received gold therapy relapse after stopping the drug.

6 Extreme care must be used during gold therapy, and the physician must be familiar with the details of such treatment before undertaking this.

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Literature on request

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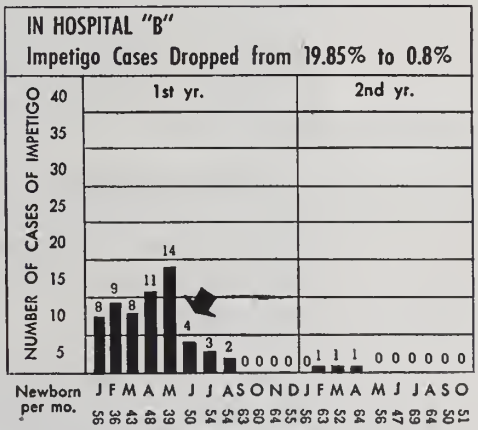
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In a study embracing 23 burned patients, nitrogen balance determinations revealed excessive urinary nitrogen excretion. Nearly all patients were in negative nitrogen balance which was most marked during the first ten days.[3]

It thus appears that protein destruction and loss are prominent and potentially detrimental sequelae of trauma, and that every effort must be made to restore nitrogen equilibrium as quickly as possible to prevent the many deleterious consequences of protein depletion. The recommendation has been voiced that "whenever possible, protein losses or deficiencies should be corrected by oral feeding."[4]

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1 Howard, J. E.: Bull. Johns Hopkins Hosp., *74*:313 (May) 1944.

2 Co Tui, C.; Wright, A. M.; Mulholland, J. H.; Barcham, T., and Breed, E. S.. Ann. Surg. *119*:815-823 (June) 1944.

3 Hirshfeld, J. W.; Abbott, W. E.; Pilling, M. A.; Hellet, C. G.; Meyer, F.; Williams, H. H.; Richards, A. J., and Obi, R.: Arch. Surg. *50*:194 (Apr.) 1945.

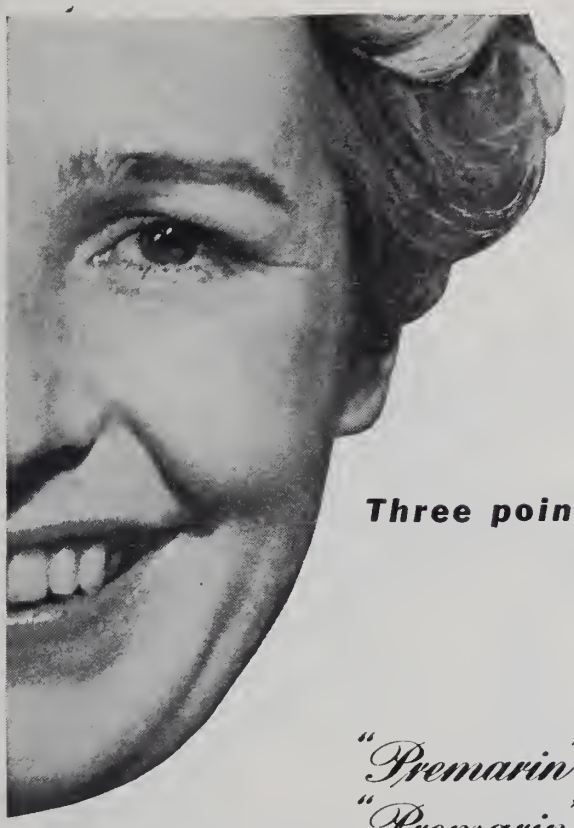
4 Lund, Chas. C., and Levenson, S. M.: J. A. M. A. *128*:95 (May 12) 1945.

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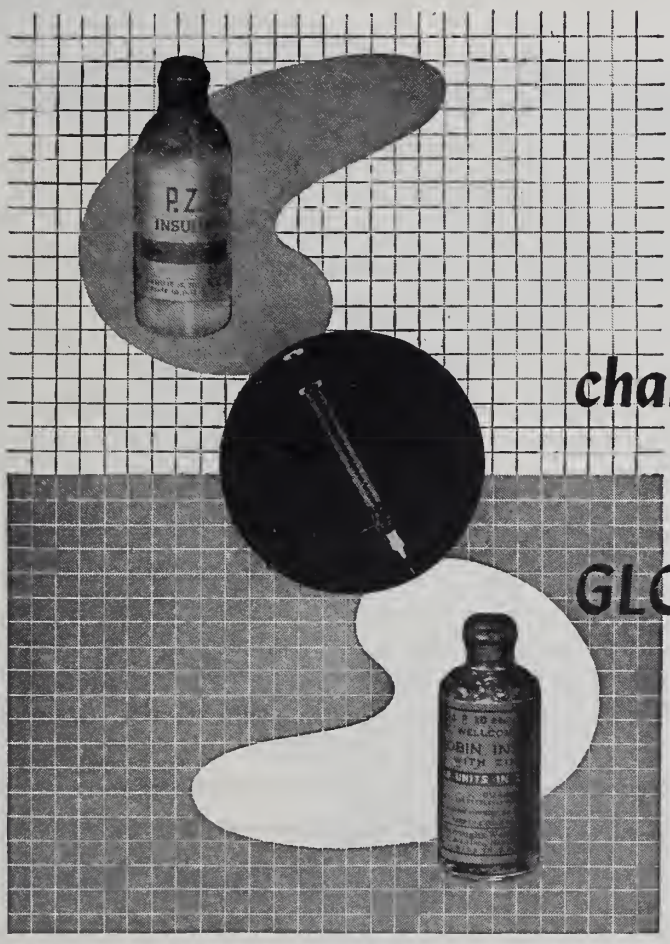
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(1) Menefee, E. E., Jr., and Atwell, R. J.: South. M. J. 39:726 (Sept.) 1946.
(2) Woodward, F. D., and Holt, T.: J.A.M.A. 129-589 (Oct. 27) 1945.



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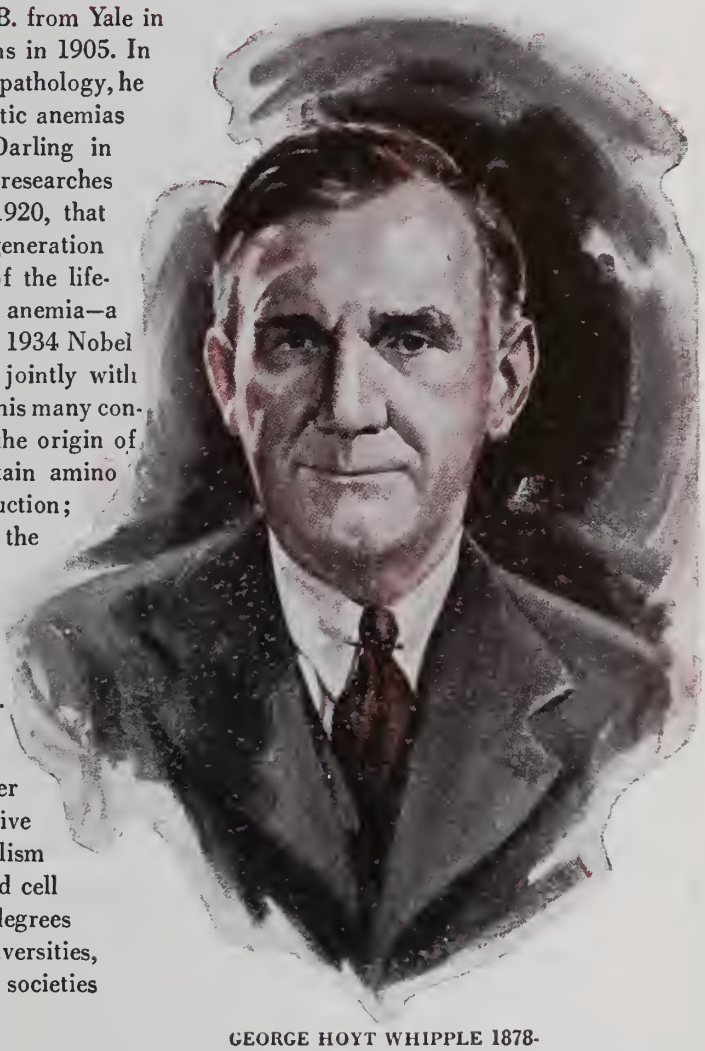
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Dr. Whipple is recognized as a pioneer in the experimental use of radioactive isotopes in the study of the metabolism of hemoglobin, plasma proteins, and cell proteins. He has received honorary degrees from many American and foreign universities, and numerous honors from scientific societies here and abroad.



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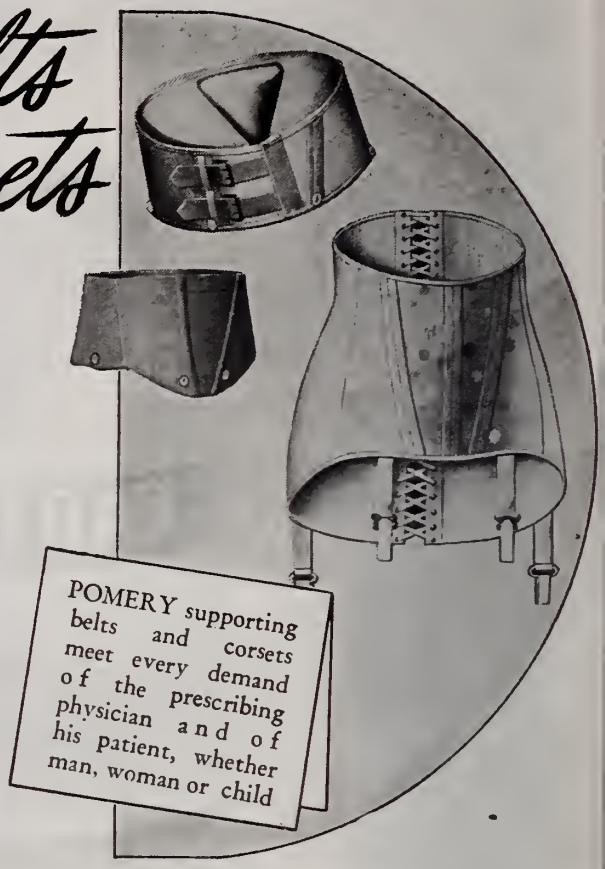
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1. Caravati, C. M., and Whims, C. B.: General Manifestations of Salicylism, South. M. J. 38:722-726 (Nov.) 1945.
2. Litchfield, H. R.: A Clinical Study of Rheumatic Fever, with Special Reference to Salysal Therapy, Arch. Pediat. 55:135-142 (March) 1938.



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[1]Human Fertility 10: 25 (Mar.) 1945.

[2]Warner, M. P.: J.A.M.A. 115: 279 (July 27) 1940.

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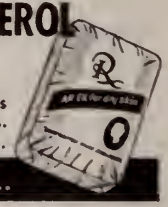
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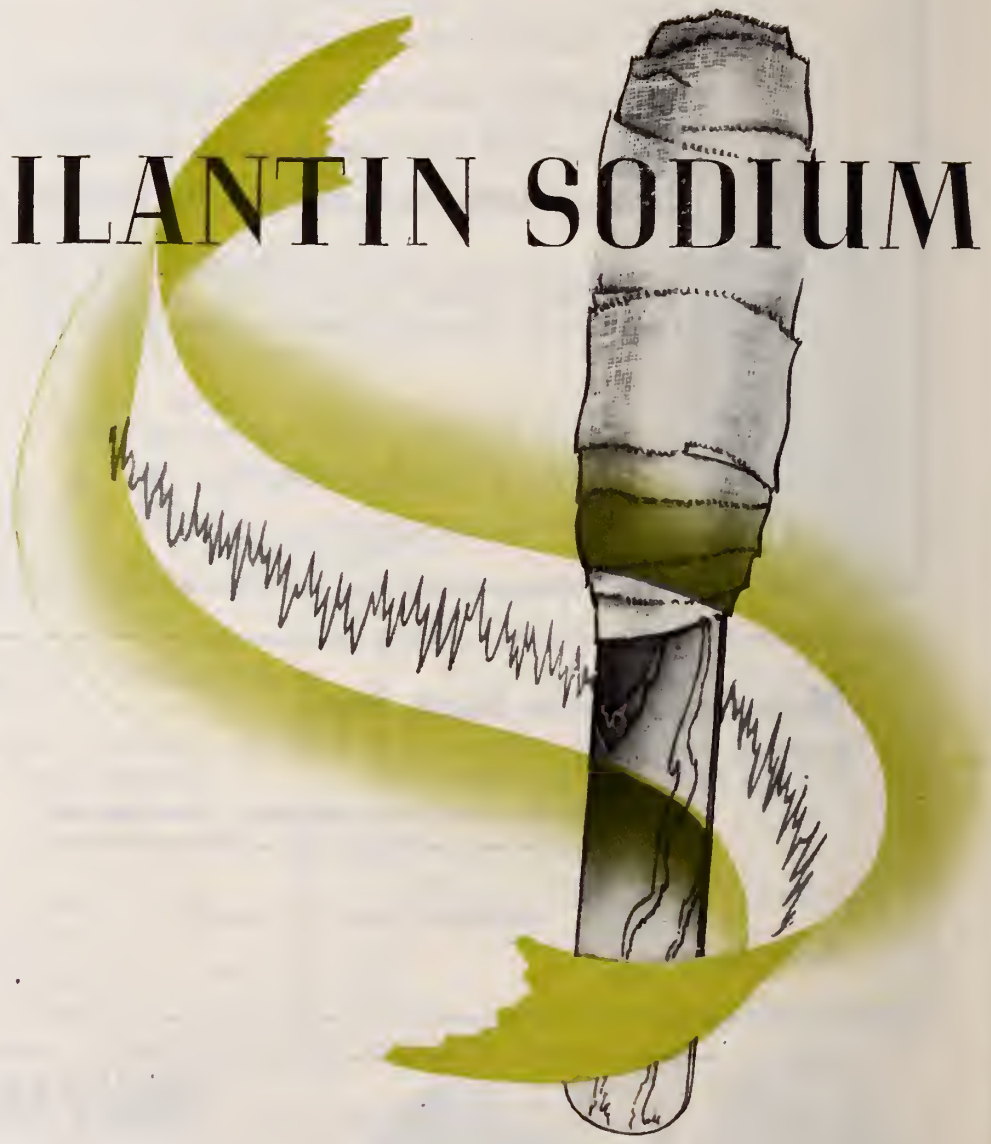
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OF

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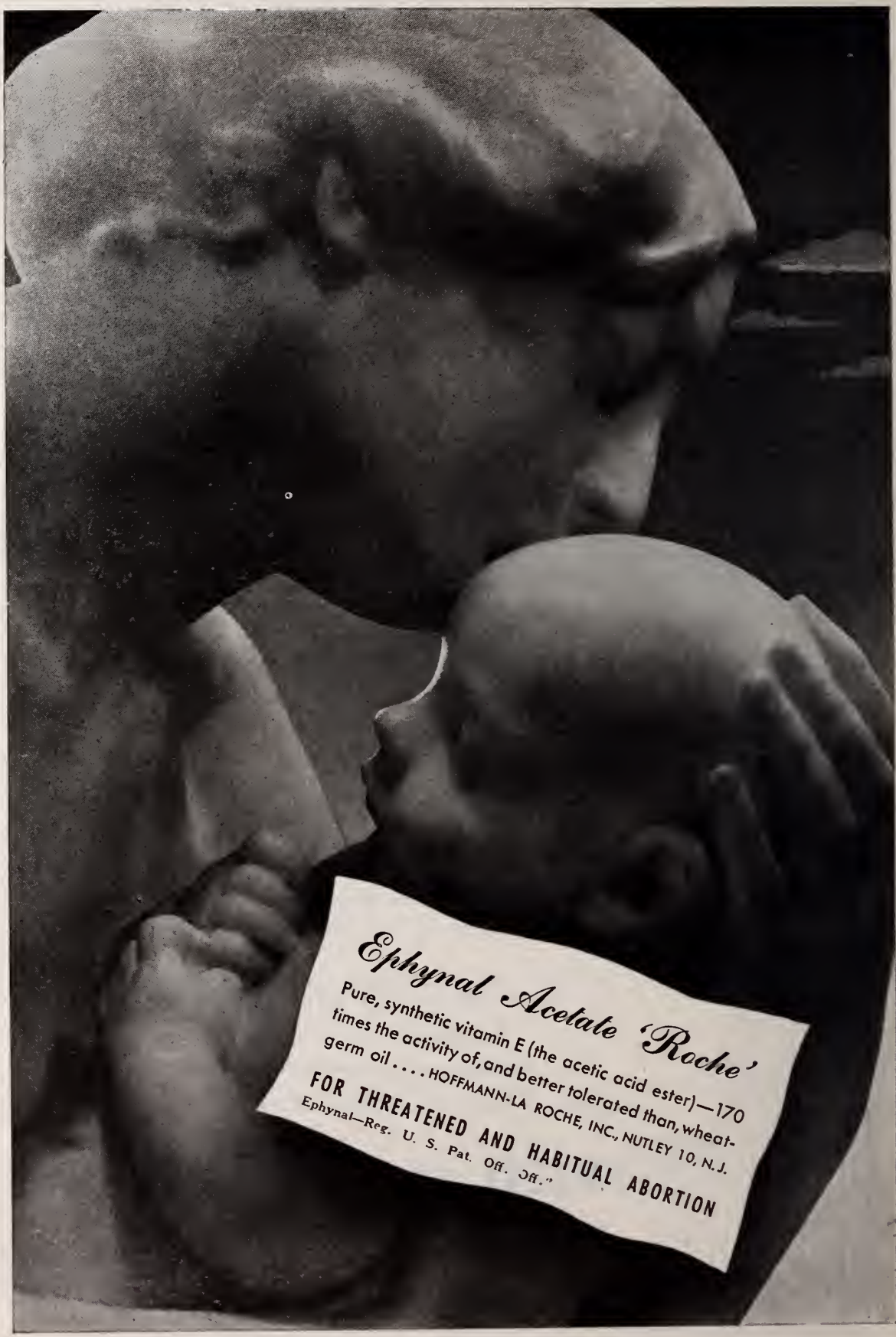
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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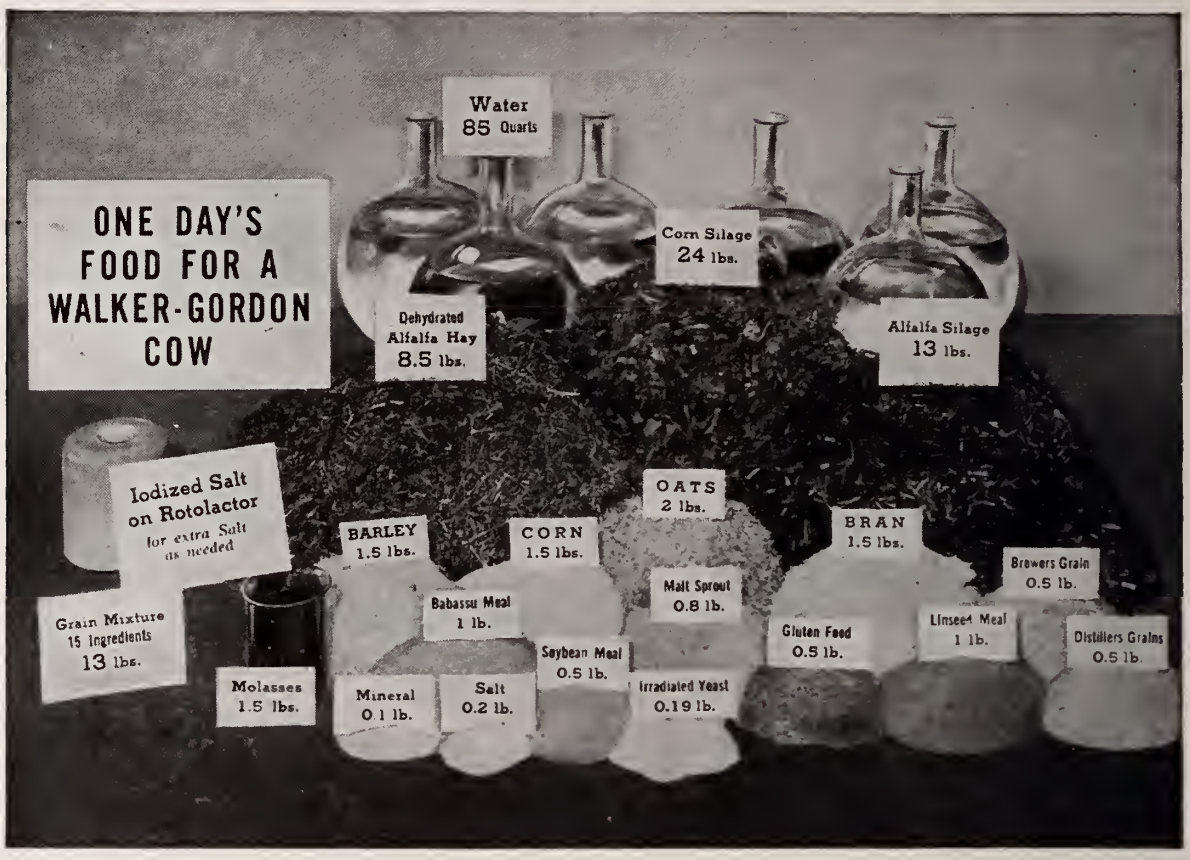
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Pyribenzamine now has been formally accepted by the A.M.A. Council on Pharmacy and Chemistry. A report to the Council on anti-histaminic agents was written by S. M. Feinberg, M.D., in the November 23, 1946 issue of the J.A.M.A. Pyribenzamine was found to be highly effective, and produces relatively few side effects.

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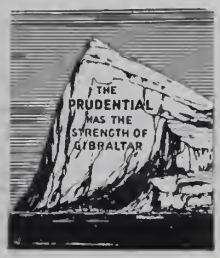
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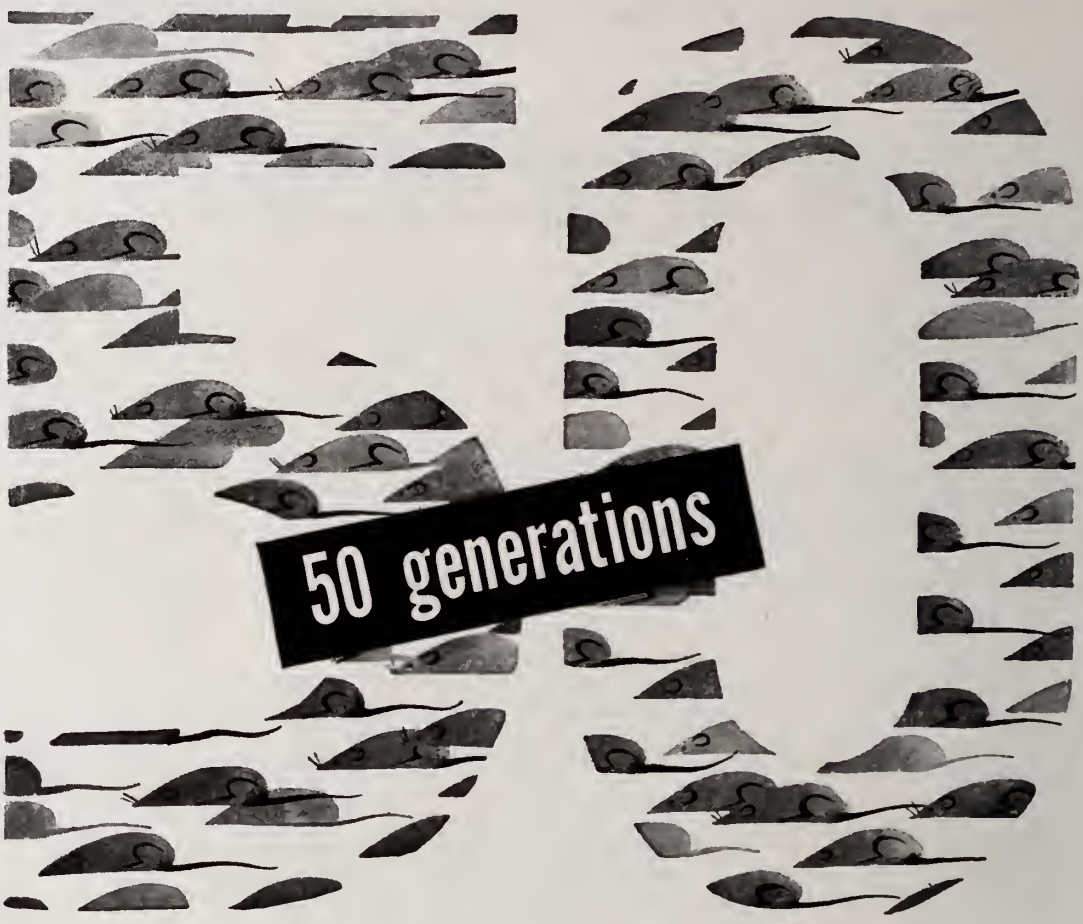
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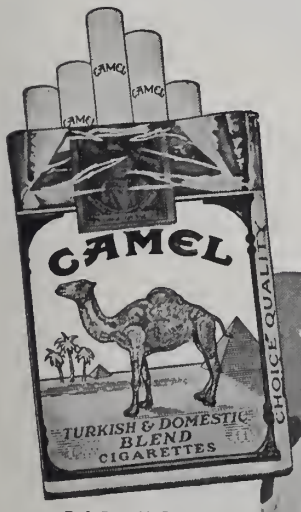
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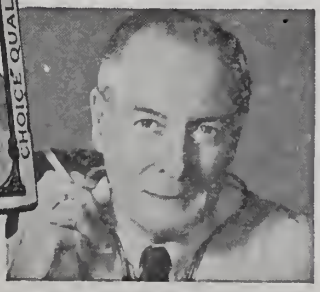
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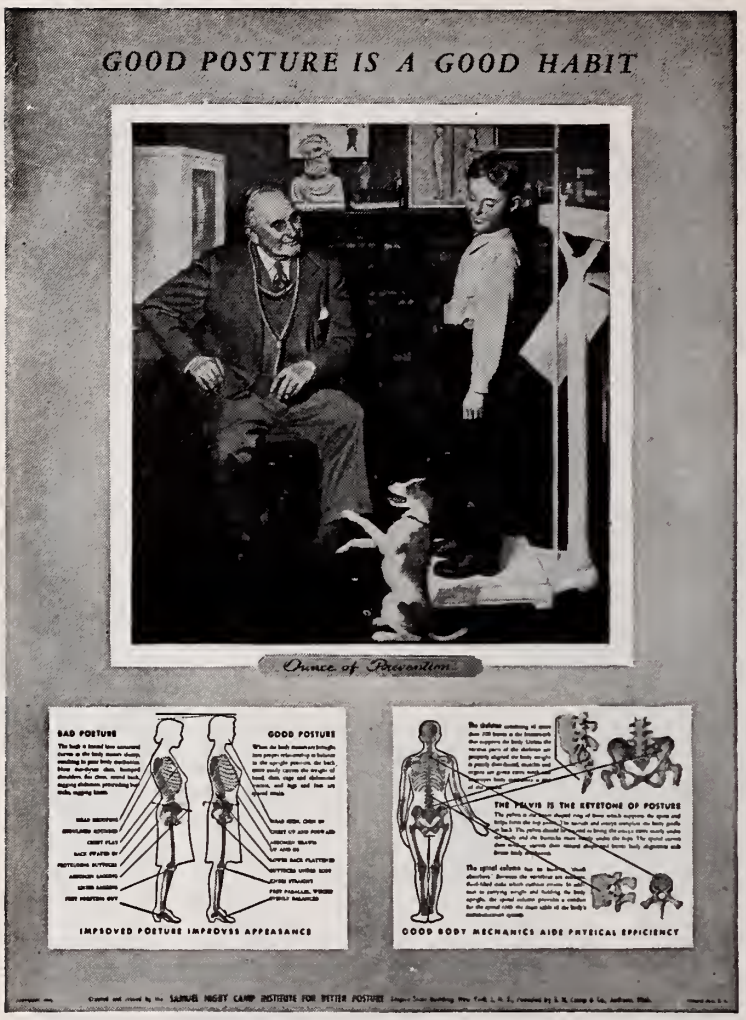
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Flying Physicians

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The research of the ethical pharmaceutical manufacturer supplements that of the physician. The Lilly Research Laboratories have been privileged to work with investigators in almost every specialized field of medicine. The scientific staff of the Lilly organization is dedicated to the principle of serving the medical profession through research.

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NEW JERSEY SPECIALTY SOCIETIES

A feature of the Annual Meeting this month will be the organization of the *New Jersey Obstetrical and Gynecologic Society* which will come into being at 11 A. M., Wednesday, April 23. All members of The Medical Society of New Jersey who devote a major part of their practices to this specialty are invited to become charter members of the infant organization, by attending the meeting at Haddon Hall.

The new society is a welcome addition to the growing list of specialty organizations of New Jersey practitioners. A half a dozen others are catalogued in the *New Jersey Doctor's Almanac* soon to be distributed with the Official List. The existence of these societies of specialists is a token of the maturity of New Jersey medicine. Constant education is the lot — and privilege — of the doctor, and in the absence of any medical school in this state, the specialty organization offers the most convenient form for that interchange of scientific ideas which is the matrix of graduate education. Membership in a national specialty society and attendance at the scientific sections of The Medical Society of New Jersey are valuable activities, but since meetings on this level are held only once a year, they do not satisfy the need for a continuing educational process.

The state specialty organization usually meets many times a year and thus provides the necessary continuity. Membership serves as a means of identification with the specialty and acceptance by colleagues. The state specialty society offers a prime mechanism for keeping up to date. The Medical Society of New Jersey salutes the new Obstetrical and Gynecologic Society and extends a note of congratulation to the alert obstetricians who have officiated at this new birth.

THE 181st ANNUAL MEETING

of

THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY

April 22, 23 and 24, 1947

OFFICIAL EVENTS

MONDAY, APRIL 21, 1947

3:00 p. m.—Registration opens
All officers, delegates, members of component County Societies, guests and exhibitors are requested to register at the Registration Desk at the entrance to the Exhibit Hall on the Lounge Floor, immediately upon arrival.

4:00 p. m.—Meeting of Finance and Budget Committee
Bakewell Room, 1st floor

8:00 p. m.—Board of Trustees' Meeting
Bakewell Room, 1st floor

8:30 p. m.—Judicial Councilors' Meeting
Green Room, 13th floor

TUESDAY, APRIL 22, 1947

9:00 a. m.—Registration opens
Lounge floor

9:30 a. m.—Inspection of exhibits
Lounge floor

11:00 a. m.—House of Delegates
Vernon Room, Lounge floor

12:00 noon—Auxiliary President's Luncheon
Mandarin Room, 13th floor

1:00 p. m.—Auxiliary Executive Board Meeting
Solarium, Lounge floor

2:00 p.m.—General Session
Vernon Room, Lounge floor

3:30 p. m.—Auxiliary Tea
Solarium, Lounge floor
All physicians' wives cordially invited

4:30 p. m.—Inspection of Exhibits
Lounge floor

6:30 p. m.—Fellows' Dinner
Bakewell Room, 1st floor

6:30 p. m.—Fellowettes' Dinner
Solarium, 15th floor

8:00 p. m.—Reference Committees' Meetings
13th floor

8:30 p. m.—Nominating Committee Meeting
Mandarin Room, 13th floor

WEDNESDAY, APRIL 23, 1947

9:00 a. m.—Registration opens
Lounge floor

9:00 a. m.—Inspection of Exhibits
Lounge floor

9:30 a. m.—Scientific Section Meetings:
Surgery
Vernon Room, Lounge floor
Obstetrics and Gynecology
Rutland Room, 1st floor
Radiology
Viking Room, 13th floor
Gastro-Enterology and Proctology
Tower Room, 13th floor

9:30 a. m.—Auxiliary Business Session
Solarium, Lounge floor

11:00 a. m.—New Jersey Chapter, American College of Chest Physicians
Roberts Room, Chalfonte Hotel

12:30 p. m.—House of Delegates (election)
Vernon Room, Lounge floor

12:30 p. m.—Jefferson Alumni Luncheon
Coral Room, Lounge floor

1:00 p. m.—Luncheons:
Auxiliary
Benjamin West Room, 13th floor
Radiological Society of New Jersey
Mandarin Room, 13th floor
New Jersey Chapter, American College of Chest Physicians
Blue Room, Chalfonte Hotel

2:00 p. m.—Scientfic Section Meetings
Medicine
Vernon Room, Lounge floor
Pediatrics
Viking Room, 13th floor
Eye, Ear, Nose and Throat
Tower Room, 13th floor

2:00 p. m.—Maternal Welfare Committee and Field Physicians
Roberts Room, Chalfonte Hotel

3:00 p. m.—Auxiliary Business Session, continued
Solarium, Lounge floor

4:30 p. m.—Inspection of Exhibits

6:15 p. m.—Social Session
Rutland Room, 1st floor

7:30 p. m.—Dinner Dance
Vernon Room, Lounge floor

THURSDAY, APRIL 24, 1947

8:30 a. m.—Auxiliary President's Breakfast
Mandarin Room, 13th floor

9:00 a. m.—Registration opens
Lounge floor

9:30 a. m.—Inspection of Exhibits
Lounge floor

10:00 a. m.—General Session
Vernon Room, Lounge floor

10:00 a. m.—Auxiliary Executive Board Meeting
Mandarin Room, 13th floor

1:30 p. m.—House of Delegates
Vernon Room, Lounge floor

GENERAL SESSIONS

TUESDAY, APRIL 22, 1947

Vernon Room, Lounge Floor

2:00 p. m.

Reconstruction Surgery of the Extremities
John J. Flanagan, M.D., Associate Orthopedist, Presbyterian Hospital, Newark

3:00 p. m.

Panel Discussion on Venereal Disease Control
Robert L. McKiernan, M.D., New Brunswick, presiding

1. Treatment of Gonorrhea and Early Syphilis with Penicillin
   J. F. Mahoney, M.D., U.S.P.H.S,, Director, Venereal Disease Research Laboratory, Stapleton, Staten Island
2. Private Physician's Role in Case Finding
   William A. Brumfield, Jr., M.D., Director of Syphilis Control, New York State Department of Health, Albany

THURSDAY, APRIL 24, 1947

Vernon Room, Lounge Floor

10:00 a. m.

Prognostic and Therapeutic Considerations in Liver Disorders

Chester M. Jones, M.D., Clinical Professor of Medicine, Harvard University Medical School, Boston

11:00 a. m.

Management of Peptic Ulcer
Samuel F. Marshall, M.D., Surgeon, Lahey Clinic, Boston

SECTION MEETINGS

Wednesday Morning, April 23, 1947

SURGERY

FRANCIS M. CLARKE, M.D., Chairman

CLYMONT MACARTHUR, M.D., Secretary

Vernon Room, Lounge Floor

9:30 a. m.

Congenital Atresias of the Alimentary Tract

Robert E. Gross, M.D., Ladd Professor of Children's Surgery, Harvard Medical School, Boston.

Discussors: Edward W. Sprague, M.D., Newark
Irvin E. Deibert, M.D., Camden

10:20 a. m.

Traumatic Aneurysms and Arterio-venous Fistulae

Harris B. Shumacker, Jr., M.D., Associate Professor of Surgery, Yale University School of Medicine, New Haven.

Discussors: H. Wesley Jack, M.D., Camden
Stuart Z. Hawkes, M.D., Newark

11:10 a. m.

The Diagnosis and Treatment of Carcinoma of the Prostate

Joseph C. Birdsall, M.D., Professor of Urology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Discussors: Meredith F. Campbell, M.D., Montclair
Charles H. deT. Shivers, M.D., Atlantic City

GASTRO-ENTEROLOGY AND PROCTOLOGY

LOUIS L. PERKEL, M.D., Chairman
SIGURD W. JOHNSEN, M.D., Secretary

Tower Room, 13th Floor

9:30 a. m.

The Unstable Colon

S. Bernard Kaplan, M.D., Chief of Gastro-Enterology, Beth Israel Hospital, Newark.

Discussors: Isaac Gelber, M.D., Elizabeth
Eugene Merliss, M.D., Newark

10:20 a. m.

Pruritus Ani: A Bio-chemo-physiologic Problem

Harry E. Bacon, M.D., Professor, and Clifford E. Hardwick, M.D., Associate in Proctology, Temple University School of Medicine, Philadelphia.

Discussors: Frank S. Forte, M.D., Newark
Julius Gerendasy, M.D., Elizabeth

11:10 a. m.

Allergy in Relation to Gastro-Intestinal Diseases

Albert F. R. Andresen, M.D., Professor of Clinical Medicine, Long Island College of Medicine, Brooklyn.

Discussors: Joseph D. Goldstein, M.D., Jersey City
Theodore Heineken, M.D., Bloomfield

OBSTETRICS AND GYNECOLOGY

ALBERT B. DAVIS, M.D., Chairman
RAYMOND T. POTTER, M.D., Secretary

Rutland Room, 1st Floor

9:30 a. m.

The Rh Factor in Obstetrics and Gynecology

Philip Levine, M.D., Director, Biological Division, Ortho Research Foundation, Raritan.

Discussor: Lyman Burnham, M.D., Englewood

10:20 a. m.

The Use and Abuse of Hormones in Obstetrics and Gynecology

Abraham E. Rakoff, M.D., Endocrinologist, Jefferson Hospital Laboratories, Associate in Gynecology, Jefferson Medical College, Philadelphia.

Discussor: Rita S. Finkler, M.D., Newark

11:10 a. m.

The Diagnosis and Management of Pelvic Endometriosis

Franklin L. Payne, M.D., Professor of Obstetrics and Gynecology, University of Pennsylvania, Philadelphia.

Discussor: Hammell P. Shipps, M.D., Camden

RADIOLOGY

JOHN L. OLPP, M.D., Chairman
WILLIAM H. SEWARD, M.D., Secretary

Viking Room, 13th Floor

9:30 a. m.

The Roentgen Findings in Functional Disturbances of the Gastro-Intestinal Tract

Paul C. Swenson, M.D., Professor of Radiology, and Willis F. Manges, Jr., M.D., Co-Author, Jefferson Medical College, Philadelphia.

Discussor: W. James Marquis, M.D., East Orange

Wednesday Afternoon, April 23, 1947

MEDICINE

ANDREW J. V. KLEIN, M.D., Chairman
CHARLES D. DRISCOLL, M.D., Secretary

Vernon Room, Lounge Floor

2:00 p. m.

Protein Therapy

Max Strumia, M.D., Associate Professor of Pathology, Postgraduate School of Medicine, University of Pennsylvania, Philadelphia.

Discussor: Frank W. Konzelmann, M.D., Absecon

2:50 p. m.

Recent Advances in the Diagnosis and Treatment of Heart Disease

J. Scott Butterworth, M.D., Associate in Medicine, Postgraduate Medical School, Columbia University, New York City.

Discussor: Louis F. Albright, M.D., Spring Lake

3:40 p. m.

Diagnosis and Treatment of Pulmonary Suppuration

Oswald Jones. M.D., Assistant Clinical Professor of Medicine, College of Physicians and Surgeons, New York City.

Discussor: William E. Wakeley, M.D., East Orange

EYE, EAR, NOSE AND THROAT

CHARLES W. BUVINGER, M.D., Chairman
Z. LAWRENCE GRIESEMER, M.D., Secretary

Tower Room, 13th Floor

2:00 p. m.

Hoarseness

F. Johnson Putney, M.D., Associate in Laryngology and Bronchoesophagology, Jefferson Medical College, Philadelphia.

Discussor: Edgar P. Cardwell, M.D., Newark

3:00 p. m.

Headaches—Impressions of an Ophthalmologist

Frank D. Carroll, M.D., Associate in Ophthalmology, College of Physicians and Surgeons, Columbia University, N. Y.

Discussor: Arthur E. Sherman, M.D., Maplewood

PEDIATRICS

L. C. VICTOR DUBUSC, M.D., Chairman
ROBERT E. JENNINGS, M.D., Secretary

Viking Room, 13th Floor

2:00 p. m.

Recent Advances in the Treatment of Influenzal Meningitis

Hattie Alexander, M.D., Associate Attending Pediatrician, Babies Hospital, Assistant Professor of Pediatrics, Columbia University, New York City.

Discussor: Horace Bell, M.D., Belleville

2:50 p. m.

Metabolism and Feeding of the Premature Infant

Samuel Z. Levine, M.D., Professor of Pediatrics, Cornell University Medical School, New York City.

Discussor: Chester R. Brown, M.D., Arlington

3:40 p. m.

Business Meeting

HOUSE OF DELEGATES

Presiding Officer, FRANK G. SCAMMELL, M.D., President, Trenton
Secretary, ALFRED STAHL, M.D., Newark

The Committee on Credentials will meet at the Registration Desk on Monday Afternoon and on Tuesday, Wednesday and Thursday mornings.

Vernon Room, Lounge Floor

First Session; 11:00 a. m., Tuesday, April 22, 1947

Order of Business

a. Call to Order
b. Organization of House of Delegates
c. Minutes of 1946 Meeting
d. Introduction of Delegates from Other States
e. Annual and Supplemental Reports

Second Session; 12:30 p.m., Wednesday, April 23, 1947

Order of Business

a. Report of Nominating Committee
b. Election

Third Session; 1:30 p. m., Thursday, April 24, 1947

Order of Business

a. Reports of Reference Committees
b. Unfinished Business
c. Installation of Incoming President, Royal A. Schaaf, M.D.
d. Adjournment

REFERENCE COMMITTEES

Tuesday Evening, April 22, 1947, 8:00 P. M.
13th Floor

Reference Committee "A", to consider reports of:
The President
The Board of Trustees
The Secretary
The Judicial Council

Reference Committee "B", to consider reports of:
The Treasurer
The Finance and Budget Committee
The Publication Committee

Reference Committee "C", to consider reports of:
The Medical Service Administration
The Medical-Surgical Plan
The State Board of Medical Examiners
The Veterans Liaison Committee
The Military Service Committee

Reference Committee "D", to consider reports of:
The Post-Graduate Education Committee
The Scientific Work Committee
The Medical Defense and Insurance Committee
The Advisory Committee to Woman's Auxiliary

Reference Committee "E", to consider reports of:
The Welfare Committee
The Subcommittees of the Welfare Committee
The Advisory Committees to the Subcommittees of the Welfare Committee

Reference Committee on Constitution and By-Laws

Reference Committee on Miscellaneous Business, to consider also reports of:
The Annual Meeting Committee
The Subcommittee on Scientific Program
Place and Date of 1948 Annual Meeting

Reference Committee on Resolutions and Memorials, and to consider report of:
The Committee on Honorary Membership

Reference Committee on Credentials
Meets at Registration Desk Monday afternoon, Tuesday, Wednesday and Thursday mornings.

DINNER DANCE

in honor of the PRESIDENT, FRANK G. SCAMMELL, M.D.
Hostesses: The Woman's Auxiliary to The Medical Society of New Jersey

Wednesday, April 23, 1947
7:30 p. m.
Vernon Room, Lounge Floor

Presentation of Fellow's Key:

To: Dr. Frank G. Scammell, President
By: Dr. Samuel Alexander, Junior Past-President

Introductions: Mrs. Frederick G. Wandall, President, Woman's Auxiliary to The Medical Society of New Jersey

Mrs. Lodovico Mancusi-Ungaro, President-Elect, Woman's Auxiliary to The Medical Society of New Jersey

Dr. Royal A. Schaaf, President-Elect, The Medical Society of New Jersey

Guest Speaker:
Honorable Alfred E. Driscoll, Governor of the State of New Jersey

SPECIAL EVENTS

TUESDAY, APRIL 22, 1947

12:00 noon—Auxiliary President's Luncheon
Mandarin Room, 13th floor
3:30 p. m.—Auxiliary Tea
Solarium, Lounge floor
All physicians' wives cordially invited
6:30 p. m.—Fellows' Dinner
Bakewell Room, 1st floor
6:30 p. m.—Fellowettes' Dinner
Solarium, 15th floor

WEDNESDAY, APRIL 23, 1947

11:00 a. m.—New Jersey Chapter, American College of Chest Physicians
Roberts Room, Chalfonte Hotel
12:30 p. m.—Jefferson Alumni Association, Luncheon
(Sponsored by the Atlantic Chapter)
Coral Room, Lounge floor
For information and reservation write to: Dr. G. Ruffin Stamps, Chairman, 300 East Verona Avenue, Pleasantville, N. J.
1:00 p. m.—Auxiliary Luncheon
Benjamin West Room, 13th floor (Fee $4.00)
Radiological Society of New Jersey, Luncheon
Mandarin Room, 13th floor
New Jersey Chapter, American College of Chest Physicians, Luncheon
Blue Room, Chalfonte Hotel
2:00 p. m.—Maternal Welfare Committee and Field Physicians
Roberts Room, Chalfonte Hotel
7:30 p. m.—Dinner Dance
Vernon Room, Lounge floor (Fee $6.00)

THURSDAY, APRIL 24, 1947

8:30 a. m.—Auxiliary President's Breakfast
Mandarin Room, 13th floor

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

TWENTIETH ANNUAL MEETING

PROGRAM

Tuesday, April 22, 1947

10:00 a. m.—Registration—Luncheon and Dinner Tickets
Lounge floor
12:00 Noon—President's Luncheon
Mandarin Room, 13th floor
1:00 p. m.—Pre-Convention Board Meeting
Solarium, Lounge floor
3:30 p. m.—Informal get-together — Tea will be served
Solarium, Lounge floor
All physicians' wives cordially invited
6:30 p. m.—Fellowettes' Dinner, by invitation only
Solarium, 15th floor

Wednesday, April 23, 1947

9:30 a. m.—General Session
Solarium, Lounge floor
Order of Business:
a. Invocation: Rev. Arthur J. Blythe, St. James Episcopal Church, Atlantic City
b. Greeting: Mrs. Charles Hyman, President, Woman's Auxiliary to the Atlantic County Medical Society
c. Response: Mrs. Lodovico Mancusi-Ungaro, President-Elect
d. Memorial Services for Departed Members, Mrs. Oswald R. Carlander, Fellowette
e. Reports
f. New Business
1:00 p. m.—Luncheon honoring Mrs. Frederick G. Wandall, President (Fee $4.00)
Benjamin West Room, 13th floor
Toastmistress: Mrs. A. Haines Lippincott
Welcome: Mrs. Frederick G. Wandall, President, Woman's Auxiliary to The Medical Society of New Jersey
Greetings: Dr. Frank G. Scammell, President, The Medical Society of New Jersey
Speaker: Dr. Frank F. Borzell, Philadelphia, Vice-Speaker of the House of Delegates of the American Medical Association
Presentation of President's Pin:
To: Mrs. Frederick G. Wandall, President
By: Mrs. A. Haines Lippincott, Senior Past-President
Entertainment: Trio
3:00 p. m.—Business Session, continued
Solarium, Lounge floor
Order of Business:
a. Unfinished Business
b. Report of Nominating Committee
c. Election of Officers
d. Inauguration of Incoming President, Mrs. Lodovico Mancusi-Ungaro
e. Installation of Officers
6:15 p. m.—Social Session
Rutland Room, 1st floor
7:30 p. m.—Dinner Dance (Fee $6.00)
Vernon Room, Lounge floor

Thursday, April 24, 1947

8:30 a. m.—President's Breakfast
Mandarin Room, 13th floor
10:00 a. m.—Post Convention Board Meeting
Mandarin Room, 13th floor

EDUCATIONAL EXHIBITS

Lounge Floor

Booth 1—New Jersey Rehabilitation Commission—Posters describing the rehabilitation services, and examples of the kind of work accomplished in the Commission's Curative Work Shop. Harry C. Harper is Chairman and Director. Dr. Henry A. Brodkin is Medical Administrative Consultant.

Booth 2—New Jersey League for Planned Parenthood, Newark—Exhibit of medical advances in in the field of planned parenthood, with charts, models and pamphlets.

Booth 3—Birthright, Inc., Princeton—Charts and literature in support of selective sterilization as the proper procedure where permanent infertility is indicated.

Booth 4—Committee on Professional Relations, Trenton—A display of New Jersey Formulary prescriptions including new preparations developed at Rutgers University College of Pharmacy through research supported jointly by The Medical Society of New Jersey and the New Jersey Pharmaceutical Association.

Booth 5—New Jersey State Organization for Public Health Nursing, Newark—A panel exhibit showing a Public Health Nurse giving service to patients together with a printed message to private physicians.

Booth 6—Newark Safety Council.

Booth 7—Cancer Control—The Advisory Committee on Cancer Control, The Medical Society of New Jersey in Cooperation with the American Cancer Society, New Jersey Division, Inc.—Educational exhibit on cancer control keynoted by the practicing physicians in New Jersey as the backbone of the cancer control program. The exhibit will include charts and descriptive material on the following topics: cancer program in New Jersey; New Jersey Moves Forward in Cancer Control; Five Thousand New Jersey Physicians Act on Cancer Control; Cancer Education Aimed at Health Maintenance Examinations by Private Physicians in New Jersey; Statewide Tumor Diagnostic Service to Bridge the Gap Between Suspected Cancer and Diagnosed Cancer.

TECHNICAL EXHIBITS

Lounge Floor

Booth 1—C. B. Fleet Co., Inc., Lynchburg, Va.—C. B. Fleet Co., Inc., welcomes you to the technical exhibits, and cordially invites you to Booth 1 where it is proud to exhibit *Phospho-Soda (Fleet)*, the one product of its manufacture. *Phospho-Soda (Fleet)* has come to occupy a significant position wherever sodium phosphates or other salines are indicated. It is a pure, stable aqueous concentrate of the two U.S.P. Sodium Phosphates with a history of more than fifty years of manufacture and ethical distribution. Should you not be thoroughly acquainted with *Phospho-Soda (Fleet)*, the representative of the booth will discuss with you the chemistry, advantages and possible application of *Phospho-Soda (Fleet)* in your practice.

Booths 2 and 3—Eaton Laboratories, Inc., New York—Eaton Laboratories, Inc., exhibit several pharmaceutical preparations of interest to the physician. *Furacin Soluble Dressing* contains a new chemotherapeutic agent, *Furacin* (brand of nitrofurazone), will be exhibited. This is a new antibacterial agent for treatment of wound and surface infections. Clinical evaluation throughout the past two and one-half years indicates a wide field of use. Our representatives will be pleased to discuss *Furacin Soluble Dressing* with all physicians. Literature and samples will be available at the Eaton Laboratories, Inc., Exhibit.

Booth 4—Lederle Laboratories, New York — Lederle Laboratories will have on display the new folic acid products about which there has been so much interest. Among the products to be shown will be *Folvite* — Lederle's brand of Folic Acid Folvron — Folic Acid and Iron, by which both iron-deficiency anemias and macrocytic anemias may be treated; also *Folvite with Liver Extract*, *Ledinac* the first protein hydrolysate to be derived from liver, will also be on display.

Booth 5—Doho Chemical Corporation, New York—The makers of *Auralgan* are introducing at this Meeting, their new sulfa drug preparation *O-Tos-Mo-San*, indicated in the treatment and control of chronic suppurative ear disease. Our representatives will be happy to explain, in detail, the workings of these medications. They will also distribute our latest series of three anatomico-pathologic charts of the ear, in color, suitable for framing.

Booth 6—E. R. Squibb & Sons, New York—Penicillin blood levels following administration of crystalline *Penicillin G Sodium in Oil and Wax* will be displayed.

Booth 7—Smith, Kline and French Laboratories, Philadelphia—*Dexedrine Sulfate and Edrisal* are featured at this exhibit. Few therapeutic agents have risen so dramatically and rapidly to preeminence as *Dexedrine Sulfate*. Today its widespread clinical usefulness in depressive states and weight reduction makes this drug undeniably the central nervous stimulant of choice. Dexedrine is remarkable in that it spares the patient the disturbing consciousness of "drug stimulation", is virtually a "single action" drug, and has an extremely wide margin of safety.

Edrisal not only affords unusually effective relief from pain, but also—because it contains *Benzedrine Sulfate* in addition to acetylsalicylic acid and phenacetin—markedly improves the patient's mental outlook: a prime objective in the symptomatic treatment of painful conditions.

Our specially trained professional representatives will be glad to answer questions concerning the possible uses of our products in your practice.

Booth 8—Thomas Nelson & Sons, New York—

Booth 9—Parke, Davis and Company, Detroit—Representatives of Parke, Davis and Company, well

informed concerning progress in pharmaceutical research, and desirous of presenting new advancements to you, will be in attendance at our technical exhibit to discuss the nature and use of new and present products. Displayed will be such outstanding products as *Theelin, Mapharsen* and *Adrenalin* preparations. The latest type of biologicals will be on display. Likewise, penicillin and other therapeutic agents of antibiotic, biologic and chemotherapeutic interest will be shown. We sincerely invite your visit to this exhibit.

Booth 10—Hoffmann-LaRoche, Inc., Nutley, N.J.—You are cordially invited to attend the Roche exhibit. It will be worth your while to drop in and glance briefly at the interesting exhibit on such clinically valuable drugs as *Prostigmin,* the versatile cholinergic stimulant: *Ephynal Acetate,* the stable, pure well-tolerated vitamin E compound; *Per-Os-Cillin,* the dependable oral penicillin tablet; *Syntropan,* the non-narcotic, well-tolerated antispasmodic; *Syntrogel,* the pleasant tasting, rapid acting, efficient antacid; and other products you may find of value in your practice. A staff of experienced Roche representatives will be present to answer your questions and assist you in any possible way.

Booth 11—Nutrition Research Laboratories, Chicago—Nutrition Research Laboratories, booth No. 11, will feature *Pendarvon Granules,* a palatable source of amino acids and vitamins of the B complex.

In addition, on display, will be *Ertron - Steroid Complex,* (Whittier) in both oral and parenteral forms. Latest scientific and clinical information continues to demonstrate the effectiveness of this drug in the treatment of chronic arthritis.

Also on display will be *Bezon,* Whole Vitamin B Complex plus Vitamin C and *Infron Pediatric,* Vitamin D, Whittier Process.

Our representatives welcome the opportunity of meeting members and guests of the Society.

Booth 12—Cameron Heartometer Company, Chicago.

Booth 13—Cameron Surgical Specialty Company, Chicago—*Cameron Instruments are available.* See the new models. See the highest powered (yet coolest) headlight in the world. See the latest electro-surgical units now available in seven sizes—from the little office unit weighing only ten pounds to a combination 2 tube 4 gap unit for major surgery. See the most modern flexible gastroscope. Our electrically lighted diagnostic instruments (on display) are as good as they always have been. We do not know how to make them better.

Booth 14—The Mennen Company, Newark—The Mennen Company will exhibit their baby products—*Mennen Baby Oil* and *Mennen Baby Powder.* Also, in addition, their fungicidal foot powder—*Quinsana,* as well as *Quicool Powder.*

Booth 15—Mead Johnson & Company, Evansville, Ind.—*Amigen* and *Protolysate* will be on display at the Mead Johnson Exhibit. Mead Johnson has pioneered the amino acid field commercially; the products that have been described in more than one hundred and forty articles in the medical literature are this year available. Trained representatives will be at the Mead exhibit to discuss details of the new amino acid products. Shown also will be *Dextri-Maltose, Pablum, Pabena, Oleum Percomorphum* and the other Mead products used in infant nutrition.

Booth 16—Burroughs Wellcome & Co., Inc., New York—Burroughs Wellcome & Co., New York, cordially invite physicians to their exhibit of a representative group of fine pharmaceuticals and chemicals. Of particular interest are *Nutragest,* the palatable dietary compound containing the amino acids, important minerals, Vitamins and carbohydrates; *Digoxin,* a pure, stable, crystalline glycoside of digitalis lanata, combining uniform potency with rapidity of action; *'Wellcome' Benzyl Benzoate Emulsion* the 24-hour treatment for scabies and pediculosis capita; and *'Lubafax'* brand surgical lubricant.

Booth 17—Camel Cigarettes, New York—Camel Cigarettes will present a dramatic full color review of their recent medical research on smoking, as well as the details of the nationwide survey showing that "More Doctors Smoke Camels Than Any Other Cigarette." Another panel will illustrate the absorption of nicotine in the respiratory tract. Representatives will be present.

Booth 18—Sharp & Dohme, Inc., Philadelphia—Sharp & Dohme extend a cordial welcome to all visitors at booth 18. New antibiotic preparations including *'Prothricin'* nasal decongestant and *'Tyroderm',* tyrothricin cream are being featured along with *'Sulfathalidine'* and *'Sulfasuxidine',* intestinal bacteriostatic agents. *'Lyocyte'* Powder, dried human blood cells and *'Lyovac'* Normal Human Plasma complete the items on exhibit.

Booth 19—Coca-Cola Company, Atlanta—Ice-cold Coco-Cola will be served to the delegates through the joint cooperation of Coca-Cola Bottling Company, Atlantic City, and the Coca-Cola Company.

Booth 20—Alkalol Company, Taunton, Mass.—W. J. Ford and A. K. Mills, Jr., representatives *Alkalol*—the balanced, alkaline, saline solution for the treatment of mucous membranes and irritated tissues. Bland — non-toxic — effective. favorite since 1896. *Irrigol* is a powder which in solution makes an aseptic slightly astringent vaginal douche. It is widely used also for colonic irrigations and as an effective rectal enema.

Booth 21—Bilhuber-Knoll Corp., Orange, N. J.—For the latest on the fine medicinal chemicals of the Bilhuber-Knoll Corp., visit Booth No. 21. Their display includes the new vasopressor, *Oenethyl;* antispasmodic, *Octin;* sedative and mild hypnotic, *Bromural;* analgesic and cough sedative, *Dilaudid;* aneleptic and antianoxiant, *Metrazol;* and myocardial stimulant and diuretic, *Theocalcin,* as well as other dependable prescription chemicals. They are prescribed alone or in combination to meet the individual patient's requirement.

Booth 22—Hanovia Chemical & Mfg. Company, Newark.

Booths 23 and 24—Pet Milk Sales Corporation, St. Louis—A complete display of material illustrating the time-saving Pet Milk services available to physicians. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

Booth 25—Philip Morris and Company, Itd., Inc., New York—Philip Morris & Company will demonstrate the method by which it was found that

Philip Morris cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiologic effects of smoking.

Booth 26—Nestle's Milk Products, Inc., New York—As the latest of its many services to the medical profession, Nestlé's Milk Products, Inc., now offers to the physician interested in infant feeding a brand new booklet, *Your Baby's Formula,* profusely illustrated and authoritatively written. This is designed to fill a real need of the physician: that of giving complete and accurate instructions to the mother on how to prepare her baby's formula. Data on the formula itself is all that needs to be supplied by the doctor.

Booth 27—G. D. Searle & Co., Chicago—G. D. Searle & Co., booth 27 will show a number of products of Searle research which have contributed so much to the armamentarium of the physician, including Searle *Aminophyllin, Metamucil, Ketochol, Floraquin. Diodiquin, Pavatrine, Pavatrine with Phenobarbital, Gonadophysin,* and *Tetrathione.*

Featured will be the new *Aminophyllin Supposicones,* the Searle brand of aminophyllin suppositories, which remain stable at temperatures up to 130 F, but which liquefy readily under conditions of use.

Booth 28—Faulhaber & Heard, Inc., Newark—Professional Liability Protection—Twenty-fifth Anniversary. The value of this association is evident by the continuity of this insurance service to the members of The Medical Society since 1922.

Any member who desires information in connection with professional liability protection, a feature of membership, can obtain full particulars at Booth No. 28, maintained by Faulhaber & Heard, Inc., 31 Clinton Street, Newark, the official broker of The Medical Society of New Jersey.

Booth 29—E. and W. Blanksteen, Jersey City—E. and W. Blanksteen, Manager, Professional Group Department, National Casualty Company, Jersey City, N. J.—A substantial majority in excess of 50 per cent of the members of The Medical Society of New Jersey have subscribed to the non-cancellable group plan of accident and health insurance issued by the National Casualty Company. New members and those returning from military service have sixty days from the date of their election to membership or return from military service in which to apply and be sure of being included in this group insurance program regardless of past medical or insurance history or present physical impairment. Other members who have not yet joined the group may still apply and be included if their applications meet the company's underwriting requirement.

Booth 30—Borden Company, New York—*Gerilac,* a vitamin-fortified powdered milk for well-rounded nutrition in convalescence, pre- and post-operative diets, geriatrics, pregnancy and lactation, and soft and liquid diets. *Gerilac* has a pleasing bland taste and variety may be enjoyed by the addition of flavors, such as vanilla, chocolate, etc. It may be served either as a beverage or used in cooking and baking.

Likewise exhibited will be our long established products for infant feeding; *Biolac, Dryco, Mull-Soy, Merrell-Soule Special Milks,* general purpose *Klim* and *Beta Lactose.*

Booths 31 and 32—Picker X-ray Corporation, New York—Picker X-ray Corporation will exhibit their *Century* apparatus. This unit is a complete self-contained diagnostic installation for radiology and fluoroscopy in all positions. This apparatus is available in either 100 or 200 milliampere capacity.

Booth 33—Lanteen Medical Laboratories, Inc., Chicago—Lanteen Medical Laboratories, Inc., Chicago 10, Illinois, cordially invite you to their exhibit of their well known pharmaceutical specialties. Included will be natural and synthetic estrogenic products, *Estrogel* and *Hexypheen, Vi-Teens* products, including *Vi-Teens Homogenized* vitamins as well as their line of gynecic specialties.

Booth 34—Schering Corporation, Bloomfield, N. J.—The Schering booth will feature the potent oral estrogenic hormone, *Estinyl,* (ethinyl estradiol) the oral progestin, *Pranone* (anhydrohyldoxyprogesterone) and the oral androgen, *Oreton-M* (methyltestosterone). The well-known parenteral hormones, *Oreton* (testosterone propionate), *Progynon-B* (estradiol benzoate), *Proluton* (progesterone), and *Cortate* (desoxycorticosterone acetate) will also be displayed. The new effective treatment for ophthalmic infections, *Sodium Sulfacetimide Solution* 30% will be of interest as will be the clinicially safer sulfonamide combination *Combisul-TD* and the radiographic media *Priodax* and *Neo-Iopax.* Schering professional service representatives will be present to welcome physicians' inquiries.

Booth 35—Ciba Pharmaceutical Products, Inc., Summit, N.J.—Ciba Pharmaceutical Products, Inc. Summit, New Jersey, invite you to visit their exhibit for latest information on *Pyribenzamine,* the new antihistaminic and anti-allergic compound. Also featured will be *Privine HCL,* the effective long-lasting nasal vasoconstrictor; *Metandren linguets,* the most potent orally active androgenic hormone available in a suitable form for sublingual absorption; *Trasentine,* a synthetic antispasmodic capable of relieving spasticities of the smooth muscle of the hollow viscera; and *Trasentine-Phenobarbital,* a combination of *Trasentine* with the well-known sedative, phenobarbital.

Representatives in attendance will gladly answer any questions that you may have concerning these and other Ciba preparations.

Booth 36—Eli Lilly and Company, Indianapolis—The Lilly exhibit this year features an interesting presentation on the heart and a discussion on cardiac drugs. Many Lilly products are to be on display; representative literature will be available. The attending Lilly medical service representatives will be pleased to assist visiting physicians whenever possible.

Booth 37—C. R. Sturm, Cliffside Park, N. J.—C. R.Sturm, Cliffside Park, N. J., serving the medical profession for over 30 years, will exhibit his famous line of physio-therapy equipment, built by Terma, specializing in short wave diathermy machines designed to meet all requirements of the Federal Communication Commission.

At his booth, the latest model "Scope-Multosine Generator" will be demonstrated with the built-in oscilloscope visualizing the pattern and shape of waves of the selected low volt current.

A full line of surgical instruments will be displayed, also appliances for the daily need of physi-

cians and hospitals, as needles, syringes, diagnostic sets, bandages, bags, aerosol inhalators, infra-red, ultra violet ray, magnifying lamps, blood pressure units, microscopes, micro-sedimentation sets, pumps and other items. Do not fail to call at his booth No. 37.

Booth 38—C. V. Mosby Company, St. Louis— New books and recent editions to be displayed at Booth 38 by the C. B. Mosby Company will include Clendening-Hashinger *Methods of Diagnosis,* Treiger *Atlas of Cardiovascular Diseases,* Rubin *Uterotubal Insufflation,* Ackerman-Regato *Cancer,* Mobley *Synopsis of Operative Surgery,* Tassman *Eye Manifestations of Internal Diseases,* and Key-Conwell *Fractures, Dislocations and Sprains.* Your examination of any of these, as well as the many other timely texts to be shown, is welcomed.

Booth 39—Endocrine Company, 4409 Park Avenue, Union City—Featuring the "oral injection" for intensive B1 therapy: 50,000 international unit *Thiamine Concentrate.*

Your alternate or adjunct to all-too-often- painful thiamine injections. Stop by for a sample. This product you can test yourself.

Booth 40—Reed & Carnrick, Jersey City — *Meprane,* a new synthetic estrogen which affords prompt relief of menopausal symptoms and imparts a sense of well-being without unpleasant side reactions, is being featured at the Reed & Carnrick booth.

Literature and samples are available.

Booth 41—Doak Company, Inc., Cleveland, Ohio.

Booth 42—Holland-Rantos Company, Inc., New York—You are cordially invited to visit the Holland-Rantos Booth where on display will be the nationally known and universally used *Koromex* contraceptive specialties. Besides the new *Koromex Set Complete,* which is a package combining the necessary items for complete contraceptive technic, there will be the new *Nylmerate Jelly,* introduced only a short time ago and received enthusiastically for the treatment of trichomoniasis and vaginal discharges of non-specific origin.

Representatives of the company will be on hand to answer all questions. Samples of *Nylmerate Jelly* and *Koromex Jelly* will be available, as will be copies of the new physician's patient instruction chart.

Booth 43—Schenley Laboratories, Inc., New York—The Schenley Laboratories' exhibit is devoted entirely to penicillin and penicillin products, and features clinical illustrations of treated patients. The complete apparatus for penicillin aerosol treatment of respiratory infections by inhalation is demonstrated to interested physicians by well-informed attendants at the booth. Descriptive literature concerning this treatment method and various Schenley Laboratories' products is supplied on request.

Booth 44—Merck & Co., Rahway—The discovery of penicillin by Sir Alexander Fleming is now a well-known story. Since then important strides have been made in the virtually unlimited field of antibiotic chemistry. With increased knowledge concerning penicillin, it is known that there are at least four individual forms, namely penicillin G, F, K, and X. The G form is of most importance in medicine today, and it is this form, in high purity and without the presence of the F, K, and X entities, that is supplied as *Crystalline Penicillin G Sodium Merck.*

Streptomycin, now also well known to the medical profession for its established value in the treatment of certain diseases, as well as its potential value in others, is the result of a research program brilliantly conceived and methodically carried through to a successful conclusion. Streptomycin was discovered by Dr. Selman A. Waksman, microbiologist at the New Jersey Agricultural Experiment Station at Rutgers University. Merck production of streptomycin has been steadily increased so that adequate supplies are available for medical needs.

Antibiotics have been chosen by Merck for their display at the 1947 Annual Meeting of The Medical Society of New Jersey. Chemical, pharmacologic and medical information is available.

Other fields, medical and nutritional, in which The Merck Research Laboratories are vitally interested, include the amino acids, the vitamins, the sulfonamides, choline derivatives, and anesthetic agents.

Booth 45—L. & B. Reiner, New York—We invite your investigation of the *Epl Cardiotron,* the first successful direct-recording electrocardiograph. A visit will show you why this has been called "the greatest advance in electrocardiography in 20 years". Note such exclusive features as the automatic time check, complete interference elimination, and complete lack of base line wandering, the last two being added features of our new model. Let us produce for you an instantaneous, permanent, accurate recording on yourself.

Also on display will be found the *Jones Motor-Basal Metabolism* apparatus. This unit has become the standard of metabolism accuracy and efficiency throughout the world. The exclusive features of the *Jones* include automatic check on accuracy, elimination of the use of barometer and thermometer and complete patient comfort. Orders can be placed for immediate delivery.

Booth 46—Gerber Products Company, Fremont, Mich.—Come in and see us at the Gerber's Baby Foods booth. Booklets are available on infant feeding as well as tested recipes for toddlers and adults on special diets. Professional reference cards give food values and chemical analyses of Gerber's foods. Samples of Gerber's new *Strained Barley Cereal* and the already popular *Cereal Food* and *Strained Oatmeal* are also available.

Booth 47—J. B. Lippincott Company, Philadelphia—J. B. Lippincott presents a complete line of Lippincott selected professional books and journals.

Be sure to see the current issue of *American Practitioner*—the monthly medical journal designed to shorten the lag between experiment and practice.

Titles of new books and new editions include: White and Geschickter, *Diagnosis in Daily Practice; Signs and Symptoms—Their Clinical Interpretation,* edited by Cyril M. MacBryde; Bancrofe and Wade, *Surgical Treatment of the Abdomen;* Kracke, *Color Atlas of Hematology;* Watkins, *Physical Medicine in General Practice;* Wolf, *Essentials of Otolaryngology;* Elliott, *Textbook of Neuroanatomy;* and Shapiro, *Applied Anatomy of the Head and Neck.*

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INTERNATIONAL COLLEGE OF SURGEONS

FELLOWS OF THE INTERNATIONAL COLLEGE OF SURGEONS STATE OF NEW JERSEY ADMITTED IN 1946

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Dr. B. L. Clement ..... Newark
Dr. H. N. Comando ..... Newark
Dr. S. E. Dalton ..... Atlantic City
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Dr. J. L. Flax ..... Newark
Dr. F. S. Forte ..... Newark
Dr. Oscar Glass ..... Newark
Dr. William H. Goldstein ..... Arlington
Dr. Stuart Z. Hawkes ..... Newark
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Dr. Charles A. Hoffman ..... Plainfield
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Dr. Horace W. Jack ..... Camden
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Dr. Raymond A. Taylor ..... Lakewood

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THE MEDICAL SOCIETY OF NEW JERSEY
ANNUAL REPORTS TO THE HOUSE OF DELEGATES
APRIL 22-24, 1947

PRESIDENT

Frank G. Scammell, M.D., Trenton

The past year has seen the completion of the transition of State Medical Society activities from those of a war period to those of peace time. Those of our members who were enrolled in the Medical Corps of the armed services have, with a few exceptions, returned to civil practice and by this time most of them have reestablished themselves in their home communities and have resumed their former hospital and other professional activities. Our Society should not soon forget the patriotic service which our members gave to our country at great personal sacrifice and all of us must continue our efforts to help them in any difficulty which they may have in effecting readjustment to private practice.

At the beginning of this administration the most urgent problem before the Society was the medical care of the veteran. At the time of the last Annual Meeting, our contract with the government had just been cancelled and a new one was in process of negotiation. Under this contract we secured the services of Dr. Edward T. Yorke to act as Liaison Officer between The Medical Society of New Jersey and the Veterans Administration. Dr. Yorke has rendered invaluable service to us in this capacity and he has done much to bring about cooperation between the two groups. Under the vigorous leadership of the indefatigable Joseph F. Londrigan, the Veterans Liaison Committee has set up a number of corporate bodies throughout the state, each one bearing the name of the component county society which sponsored it. These corporate bodies are to develop examining units to carry out the pension examinations for the Veterans Administration when this service is requested by the government. At present such examining units are functioning in Hudson and Monmouth Counties and other are to be developed as the need arises. In certain counties (such as Essex and Passaic) existing facilities in the regional offices of the Veterans Administration are adequate and examining units are not functioning. However, the mechanism has been set up and can begin to operate whenever called upon by the Veterans Administration. The medical treatment of veterans for service connected disabilities for the most part is being carried out by private physicians who have signified their willingness to participate in the program and have agreed to accept payment for such services according to the schedule of fees drawn up jointly by the Veterans Administration and The Medical Society of New Jersey. This part of the Veteran's medical care program is operating very satisfactorily to the government as well as to the physicians of this state.

The Medical Service Administration and the Medical-Surgical Plan under the direction of Dr. Norman M. Scott have made excellent progress in their effort to solve the problem of the distribution of medical care in New Jersey. The Medical-Surgical Plan now has nearly 100,000 beneficiaries enrolled and is growing as rapidly as we could wish. This Plan represents a successful venture in the field of voluntary sickness insurance and as a Society, we can be justly proud of our contribution to the general welfare of our people.

Although since the last election the Wagner-Murray-Dingell Bill has apparently gone, at least temporarily, into eclipse, there are many legislative problems which require constant study and unrelenting vigilance. The Legislative Committee under its Chairman, Dr. Berthold S. Pollak, and its Executive Secretary, Dr. Frederic J. Quigley, have as usual, rendered us yeoman service during the past year.

Special mention should be made also of the outstanding work of the Advisory Committee on Cancer under the Chairmanship of Dr. W. O. Wuester. This committee has cooperated wholeheartedly with the New Jersey Chapter of the American Cancer Society and is assisting that group to set up suitable facilities for the diagnosis and treatment of cancer throughout the state. A notable contribution of this committee has been the development of the new biopsy service and the new central tumor registry.

I would like to record recognition of all the excellent work done by the various other committees, Welfare, Public Health, Public Re-

lations, Medical Practice, etc., but I cannot do so adequately within the limits of this brief report. I wish all of the chairmen and members of the committees to accept my expression of deep appreciation for their individual contribution to the welfare of the Society during my term of office.

The work of the Publication Committee has been especially praiseworthy. Under the able chairmanship of Dr. Henry C. Barkhorn and the brilliant editorship of Dr. Henry A. Davidson, the JOURNAL has reached new heights of usefulness to our members. Attention is called to the 500th issue of the JOURNAL which was published in April 1946 and especially to the first editorial which is a masterpiece of wit and stimulating editorial writing. It bears rereading.

A noteworthy event during the past year was the completion of the plans for the New Jersey Health Congress, the development of which was initiated by The Medical Society of New Jersey. This organization now has as its first president, Dr. Stanley H. Nichols, who did so much to bring it into being. The Congress promises much for the future in bringing about adequate distribution of medical care to all the people of New Jersey. My thanks go to Dr. Nichols especially for his excellent work in this project.

The Society has been seeking the services of an Executive Officer, but up to this writing we have been unsuccessful in securing a physician who has the necessary qualifications for the position. Our search will be continued and we are hopeful that a suitable man will be found in the near future.

At this time I wish to note with sincere regret the loss of three of our most valued members, Dr. Wells P. Eagleton, Dr. Harry R. North, and Dr. C. C. Beling, all of whom contributed so much to the welfare of this Society over so many years. Their places will not soon be filled.

I am grateful also to Dr. Samuel Alexander, the immediate past president, for his continued interest in the affairs of the Society.

This brief report would be wholly inadequate were I to omit special mention of the loyal cooperation of Mrs. Edith L. Madden and her competent staff in carrying out the arduous and detailed work of our central office. Their industry and willingness are quite unusual.

In conclusion I wish to express my sincere thanks to the officers and trustees for their unfailing and sympathetic support during the past year. This report would not be complete without my publicly acknowledging the great assistance given me by the president-elect, Dr. Royal Schaaf, who now will assume the office of president of this honorable body. His untiring efforts, his versatile handling of the various momentous subjects that have presented themselves before the Society while I was invalided, has been your gain and not my loss.

Another notable situation in conjunction with the unusual standing of this Society is that we are celebrating the Annual Meeting by having for the first time in its history, as far as I am able to determine, as our guest for the banquet, the Governor of New Jersey and his wife. Camden County has sent many illustrious men to all parts of the state and also to this honorable Society, but it is the first time in 102 years that they have found out they had the material for one of the best Governors of the State of New Jersey coming from their county.

SECRETARY

ALFRED STAHL, M.D., Newark

Statistical report on the Official List of Members of The Medical Society of New Jersey, as of March 1, 1947:

Paid-up Members, 1947	
Active	4325
Associate	305
Members in Service, 1947	
Active	66
Associate	7
Members Deceased, March 1946-March 1947	52
Transfers, March 1946-March 1947	
In from Other States	28
Out to Other States	40
Within State	25
Resignations, March 1946-March 1947	9
New Members	202
Reinstated Members	38
Delinquencies (Members in 1946, not paid at time of Official List closing)	394

TREASURER'S REPORT

George J. Young, M.D., Morristown

As the fiscal year does not close until May 31, 1947, the annual report cannot be submitted at this time. An interim report covering the accounts up to that time will be presented to the House of Delegates at its Annual Meeting this April.

BOARD OF TRUSTEES

Aldrich C. Crowe, M.D., Chairman, Ocean City

The present Board of Trustees held its organization session in Atlantic City during the Annual Meeting on May 23, 1946. Officers were elected and the necessary committees appointed. On June 16, 1946, a second meeting was held—this time in Trenton. Activities of this meeting were printed on page 284 of the July Journal. The Trustees at that time approved the new contract with the Veterans Administration and set up the Veterans Liaison Committee, held a conference with our A.M.A. delegates, sent to the Governor nominations for the State Board of Medical Examiners, re-appointed employees of the Society's office staff, and approved of recommendations made by the Medical Service Administration and the Medical-Surgical Plan.

On September 29, 1946, we met again. Page 462 of the November Journal reviews our activities at that meeting. At this meeting, Dr. Sica was elected to the Board, Dr. Hurff was nominated as A.M.A. delegate, and Dr. A. J. Conty was elected to the Finance and Budget Committee. Study was made of the problem of remission of dues to members returning from the Army and Navy. Many recommendations of the Welfare Committee were analyzed and appropriate action taken. Steps for incorporating county veteran care plans were taken. The preparation of the *New Jersey Doctor's Almanac* was authorized and plans were begun for the 1947 Annual Meeting.

Our meeting of January 26, 1947, is detailed on page 59 of the February Journal. A new edition of the *New Jersey Formulary* was authorized, and resolutions on auxiliary medical services were studied and implemented. The Trustees held another meeting on March 16, 1947, and this will be reported in the May 1947 Journal.

Meetings were well attended, and there was an excellent and alert participation by all the Trustees.

JUDICIAL COUNCIL

FIRST DISTRICT

Essex, Morris, Union and Warren Counties

Francis C. Weber, M.D., Councilor
Newark

Since my appointment by the Board of Trustees to fill the vacancy caused by the death of Dr. C. C. Beling, nothing has been presented to me for action.

Looking through Dr. Beling's file I can report that nothing was presented to him for his attention.

Therefore, there is no unfinished business and no problems on the docket for consideration.

SECOND DISTRICT

Sussex, Bergen, Hudson and Passaic Counties

Vincent P. Butler, M.D., Councilor
Jersey City

As Councilor for the Second District, I wish to report that no matters requiring the consideration of the Council have been brought to my attention during the past year.

THIRD DISTRICT

Mercer, Middlesex, Somerset and Hunterdon Counties

BARCLAY S. FUHRMANN, M.D., Councilor
Flemington

Your Councilor for the Third Judicial District has no report to make. There have been no calls for the services of the Councilor in this district.

FOURTH DISTRICT

Camden, Burlington, Ocean and Monmouth Counties

S. EMLEN STOKES, M.D., Councilor,
Moorestown

No problems have arisen in the Fourth District which have been called to the Councilor's attention. I have been unable to visit all the county medical society meetings in this district but I am ready to serve as the occasion arises.

FIFTH DISTRICT

Atlantic, Cape May, Cumberland, Gloucester and Salem Counties

CHESTER I. ULMER, M.D., Councilor
Gibbstown

No matters of an ethical or judicial character were brought to the attention of the Councilor of this district during the year.

It would appear that the county societies in this district are functioning well and with harmony.

STANDING COMMITTEES

FINANCE AND BUDGET

DAVID B. ALLMAN, M.D., Chairman, Atlantic City

As the fiscal year does not end until May 31, the annual report of the Finance and Budget Committee is necessarily incomplete at this time. A supplemental report will be presented to the House of Delegates at the Annual Meeting.

MEDICAL DEFENSE AND INSURANCE

J. WALLACE HURFF, M.D., Chairman, Newark

The year 1947 is the twenty-fifth anniversary year of the origin of our Committee on Medical Defense and Insurance. Its activities and achievements will be set forth in a supplemental report to be presented at the Annual Meeting.

The loss of its chairman, Dr. Christopher C. Beling, on November 30, 1946, terminated the services of one who has contributed much to the welfare of his fellow physicians and to the Society. He was the leading force in the development of the plan, and as chairman of the committee during its entire existence, his untiring efforts, his foresight and intimate knowledge of insurance problems, resulted in the development of an insurance program which is equal to, or surpasses that of any other medical society. He had but one goal: to provide every member of The Medical Society of New Jersey with the highest type of medical defense and adequate protection against claims arising out of alleged malpractice. Through his leadership, the present plan for protecting the doctor against loss of income due to accident and sickness disabilities, has shown continued expansion, broader coverage and constant growth.

At this time, there are approximately 3800 members insured under the liability policy approved by the society. The resumption of contracts on the part of veterans returning to practice, has greatly augmented the number insured over that reported last year.

Our accident and health program by reason of its non-cancellable contracts has expanded rapidly and the feature of coverage offered by the insurance company, containing liberal benefits at reasonable cost, has been responsible for the successful enrollment of greater than 50 per cent of the members of the Society.

Due to the inability of the insurance companies at this early date to furnish the committee with the usual statistical data, such as the number and character of malpractice and accident and health claims, amount of losses paid and reserves set up on outstanding cases; it will be necessary to include this information in our supplemental report.

PUBLICATION

HENRY C. BARKHORN, M.D., Chairman, Newark

Perhaps the best report of the Publication Committee is the monthly issue of the JOURNAL which, in a large measure, speaks for itself. The Committee has also carried on certain activities which are not recorded in the JOURNAL. For example, our editor was last year selected to be the discussion leader at the National Conference of American Medical Editors — the first open-discussion type of meeting held by that conference. The Committee has assumed responsibility for the preparation of *The New Jersey Doctor's Almanac,* a compact volume of useful information for the practitioner. We also prepared the article on medical services for the state's *Welfare Reporter* and our editor wrote the chapter on the medical profession for the official *New Jersey Almanac* now being prepared by Rutgers University.

The JOURNAL is making itself known on a national level. Within recent months, no less than four of our editorials have been reprinted out of the state. The editorial "Do You Know the Pharmacist?" was reprinted in a pharmacy journal and copies are also being distributed nationally through one of the country's large drug houses. Several of the editorial-obituaries have been reprinted by newspapers. The "Goodbye to the Grain" editorial attracted considerable attention and drew comment from the Pharmacopeia commission itself. The *New York State Journal of Medicine* favorably reprinted our editorial on "The Physician-Veteran and the Hospital". And the editorial called "The Vanishing Nurse" has been reprinted by the *American Journal of Nursing.*

The Publication Committee began last fall a new activity, the "County Bulletin Service". Our editorial office sends at regular intervals, a series of items of varying lengths to all county societies publishing local Bulletins. Practically 100 per cent of such items have been used and the service has been widely appreciated.

The JOURNAL itself has this year paid special attention to the publication of service-material; that is, paragraphs and tables of practical and continuing interest to the reader. In this connection, to name only a few, we have published in full the fee schedule of the Veterans Administration, lists of approved hospitals, details of cancer clinic equipment, changes in the pharmacopeia, lists of culture stations in the state, and the new dosage conversion table. These items are of such permanent value that they encourage readers to keep the JOURNAL always available.

The JOURNAL has maintained its departmentalized arrangement so that readers soon become accustomed to the order and easily find the various sections. We have added several new departments, including *Public Health News for the Physician,* lists of associates and office space available, and information on the Veterans Care Plans.

Financially, the JOURNAL remains in excellent health, and is still our Society's largest revenue-producing enterprise. Details of JOURNAL financing are found in the Treasurer's Report.

The Committee's thanks are due to Dr. Edward T. Yorke for keeping us supplied with his well-written monthly items on the Veterans Care Plans, to Dr. Norman M. Scott for his prompt, readable and important reports on our medical service plans, to Dr. S. William Kalb for his always-interesting column on nutrition, to Dr. J. Lynn Mahaffey for his regular *Public Health News* page, to Mrs. Edith L. Madden for the splendid cooperation given by the Executive Offices, to Mr. Roy F. Hill and his staff at The Orange Publishing Company for maintaining consistently high printing standards, and especially to Mrs. Miriam N. Armstrong our assistant editor, for her efficient management of the advertising department of the JOURNAL and for her untiring labors in keeping the editorial machinery operating in high gear.

COMMITTEE ON SCIENTIFIC WORK

JOHN W. GRAY, M.D., Chairman, Newark

The Committee on Scientific Work has been inactive during the past year.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

WILLIAM E. DODD, M.D., Chairman, Beach Haven

This committee has continued its efforts to bring closer relationship between the activities of the Woman's Auxiliary and the activities of the committees of The Medical Society of New Jersey. The chairman of the Advisory Committee to the Woman's Auxiliary made a personal appeal at the organization meeting of the Welfare Committee to include the Woman's Auxiliary in the overall plans of that committee and the plans of its component subcommittees early in the year. The Woman's Auxiliary is a potential force that has not been fully utilized in the past. The fault, if any, does not lie with the women, for they are anxious to help in any task assigned to them. They should be given worth while assignments early in the year in order that they may do a real job.

The committee approved the plan of activities as submitted by the President of the Woman's Auxiliary for the fiscal year of 1946-1947 which is as follows:

PUBLIC RELATIONS:

1. Extend the aims of the medical profession to all organizations interested in the promotion of health education.
2. Keep the public informed through its press and publicity and through other channels, on the advances in Medicine.
3. Publicize the Medical-Surgical Plan of New Jersey, and educate the lay people in the way it functions.
4. Cooperate with the United Safety Council.
5. Active participation in such organizations promoting health as Cancer Control, Infantile Paralysis, etc.
6. Stimulate a more united understanding among physicians' families.

ORGANIZATION:

1. Increase the membership in organized counties.
2. Solicit the interest of unorganized counties, and urge them or organize.

LEGISLATION:

1. Keep all Auxiliary members up to date on all legislation, both State and Federal, affecting the Medical profession.
2. Comply at all times with requests from the Medical Society in combating legislation unfavorable to the medical profession.

HYGEIA:

1. Promote the circulation of Hygeia among Auxiliary members and physicians.
2. Promote the circulation of Hygeia among lay people.

WIDOWS AND ORPHANS:

1. Increase the membership of Widows and Orphans Society among physicians.

A special effort was made by the president of the Woman's Auxiliary to increase auxiliary membership during the year. Efforts were made to organize auxiliaries in counties where none existed and to revive interest in the Auxiliary where interest seemed to be lagging. The Advisory Committee cooperated by appealing to the president of each county medical society to give Mrs. Wandall help in this worth while endeavor. It is gratifying to learn that because of this campaign two county auxiliaries have been reactivated and new interest in the auxiliary has been promoted.

This committee was called upon to consider the advisability of inviting representatives of the press to attend the various meetings of the Woman's Auxiliary. The committee recommended that whenever possible the press be encouraged to attend all meetings of the Auxiliary except those of strictly business nature and those in which the subject matter was of a private nature.

A wider sphere of activity for the Woman's Auxiliary is being planned on a national level; this will increase the field of usefulness of the Auxiliary and increase the interest of the members of the organization.

The committee congratulates the Woman's Auxiliary upon its efforts and accomplishments during the past year, and wishes its continued and ever increasing success in the years to come.

POST-GRADUATE EDUCATION

HENRY B. DECKER, M.D., Chairman, Camden

The Rutgers Plan for graduate training of Hospital in Camden on October 1st, 1946. Two general practitioners was started at The Cooperstudents were admitted in October and two in

January. At the end of three years it is expected that twenty-four students will be engaged in the course.

It is planned, during the next year, to establish the course in at least two other centers.

The graduate lecture courses, in cooperation with Rutgers University, will be resumed by several county societies during the next three months.

Essex County Medical Society, in cooperation with Seton Hall College, has established an excellent series of courses. Middlesex County Medical Society has operated a course in general pathology. The Atlantic County Medical Society planned a most worthwhile series of post-graduate lectures. The neuropsychiatrists in the state operated a refresher course, in Newark, of graduate quality. These last have been accomplished by the individual societies.

It must be apparent that the physicians of New Jersey are cognizant of the importance of graduate and post-graduate training.

ANNUAL MEETING

HARROLD A. MURRAY, M.D., Chairman, Newark

Once again The Medical Society of New Jersey returns to Haddon Hall for its Annual Meeting. The scientific program has been prepared with a great deal of care and it is hoped that a large number of doctors will visit the meeting and participate in the sessions.

An advance announcement was mailed to the members in January and was briefly outlined in the February JOURNAL. The final program and all details of the meeting appear on page 126 of this JOURNAL.

The committee feels that an excellent program has been planned for the benefit of the membership, and urges all who can get away for a day or more to visit Haddon Hall. Acknowledgment is made by the Committee to the Exhibitors who play such a large part in making our meeting so successful.

SCIENTIFIC PROGRAM

THOMAS MCG. BRENNOCK, M.D., Chairman, Jersey City

We are very proud of the fine scientific program which has been arranged for the 1947 annual meeting of our Society by the Section Officers. A review of the various section and general programs will show that all phases of medicine are adequately covered. Section Officers have kept the general practitioner uppermost in mind in the preparation of their programs.

All members of the Society are urged to plan at least one day in Atlantic City and sit in at some of the meetings scheduled.

The Committee wishes to place on record a special note of appreciation to the distinguished out-of-state physicians who so generously give of their time and effort to participate in our program.

WELFARE COMMITTEE

HILTON S. READ, M.D., Chairman, Ventnor

Four times this year, New Jersey's unique organization, the Welfare Committee, has assembled to provide a forum for discussion and a two-way channel for communication. Meetings have been well attended and it is heartening to all persons interested in organizational democracy to see members from all parts of the state pouring into Trenton for this veritable Town Meeting of Medicine.

This year closes a quarter of a century of Welfare Committee activities. The first report of the Welfare Committee, covering the 1921-1922 fiscal year, was devoted exclusively to problems in state legislation. In the course of time, the Welfare Committee expanded its activities until it embraced so many other fields that the present arrangement of four subcommittees became necessary. With this, has come a change in function as well as in scope. The Welfare Committee now furnishes a forum at which any member may discuss a problem. It is a body to which county so-

cieties may present queries and suggestions. And it is a source from which local representatives bring back to the counties the thinking and action of organized medicine on the state level.

The minutes of the meetings have already been published in the JOURNAL and there is no need to repeat them here. Every subcommittee has presented suggestions coming from technically skilled specialists in public relations, medical practice, public health and legislation. These suggestions have then been aired by members representing various points of view and out of that discussion have come practical plans which the Board of Trustees has implemented. The Welfare Committee has also played host to many nonmembers who had a message to bring to us or who had a legitimate interest in our work. This, another unique feature of our Society's structure, has often given a new dimension to our deliberations, since it has made it possible for us to tap the resources of allied nonmedical agencies and organizations.

The four meetings have been interesting, important, and, we think, effective. The accomplishments of the committee are reflected in the activities of the subcommittee and advisory committees reported elsewhere in the JOURNAL.

Your Chairman has enjoyed presiding over this lively committee. It has furnished him with much food for thought and has given him renewed faith in the effectiveness of the democratic process. He lays down the gavel with the assurance that the Committee remains in good hands and that it will long continue to justify its proud title, a Committee on Welfare—the welfare of the members, the welfare of the Society and above all, the welfare of the people of New Jersey.

SUBCOMMITTEES

LEGISLATION

B. S. POLLAK, M.D., Chairman, Jersey City

As this is being written (March 5, 1947) the Legislature has just reconvened. No action has yet been taken on any bills of medical or public health interest so far introduced, and thus we will be compelled to chronicle the disposition of these bills in our supplemental report.

We shall here refer to the federal legislative scene and discuss the two most significant measures from the medical viewpoint now before the Congress.

In our opinion it is a delusion to assume by reason of the 1946 Congressional election that the threat of "socialized medicine" is over. To be sure we may feel reasonably certain that the Wagner-Murray-Dingell Bill, as it appeared in the last two sessions of Congress, is unlikely to be passed for the next two years. Nevertheless it seems to us, that the impress of the New Deal is still apparent in health legislation being proposed again this year. It is pretty well understood that the Taft-Smith-Ball Bill of last year was introduced late in the session as an off-set to the Wagner-Murray-Dingell Bill. It served its purpose, and, partly in consequence, the committee did not report the Wagner-Murray-Dingell Bill.

The 1947 version of the bill by Senators Taft, Smith, Ball and Donnell (S. 545) apparently has been offered with the idea of placing all medical and health activities of the federal government in a single agency, to be known as the Federal Health Agency. And the other main objective is to make available improved medical, hospital and dental services to those in the low income group through grants-in-aid to the states.

While the Wagner-Murray-Dingell bill would impose federalization of medicine by a single process, it is realized that it is possible to impose federal control of medicine by installments. And so, while it may be conceded, speaking generally, that the main purposes of the Taft-Smith-Ball-Donnell bill are laudable, the proposal should be examined with the utmost care by the House of Delegates, with a view not only to its immediate effects, but more importantly its possible latent effects. This bill would appropriate twenty million dollars a year for the next five years to the states for medical, hospital and dental care programs. The amount which each state will receive is based upon its population and tax paying ability. New Jersey would receive $4,885,600 a year, provided at least a similar amount were appropriated by the state and its political subdivisions. A decision on supporting this bill as far as organized medicine is concerned, must be premised on a correct understanding of the principles of the Platform of the American Medical Association. The following is quoted

from the Platform of the American Medical Association, adopted by the House of Delegates, June 13, 1944:

"D. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

"The physicians of the United States have given freely of their time and of their funds for the care of the sick. Their contributions to free medical service amounts to at least $1,000,000 a day. The physicians of this country have urged that every person needing medical care be provided with such care. They have urged also the allotment of funds for campaigns against maternal mortality, against venereal disease and for the investigation and control of cancer. The medical profession does not oppose appropriations by Congress of funds for medical purposes. It feels however that, in many instances, states have sought aid and appropriations for such functions without any actual need on the part of the state, in order to secure federal funds as might be available. It has also been impossible, under present technics, to meet actual needs which might exist in certain states with low per capita incomes, with needs far beyond those of wealthier states, in which vast sums are spent.

"It is proposed here simply that Congress make available such funds as can be provided for health purposes; that these funds be administered jointly by the county, state and federal health agencies, mentioned in section H of this platform, and that the funds be allotted to proof of actual need to the federal health agency, when that need is for the prevention of disease, for the promotion of health or for the care of the sick."

It is our opinion that this bill does not conform to this principle. It appropriates monies to all states in accordance with a variable formula, without the necessity of demonstrating "actual need on the part of the state". If the measure limited appropriations solely to the ten or fifteen states of the south and southwest, which undoubtedly could demonstrate need, we are of the opinion that this bill (S.545) would conform to the principles of the Platform of the American Medical Association. If a state like New Jersey, one of the richest in the union, and other states, which are able to provide medical care for all their citizens without federal financial assistance, are to have these appropriations imposed upon them it must be realized that for a large segment of the population of all the states the federal government will of necessity have increasing authority in the practice of medicine.

The bill as presently drawn is designed to give the states wide latitude in the development and administration of these plans. However, no one can foretell how the measure may be amended before passage through both houses, and no one can foresee what future changes may be made by subsequent Congresses.

So, with respect to this bill we would suggest a decision by the House of Delegates as to whether, in its opinion, this bill violates the Platform of the American Medical Association. If it is the opinion of the House of Delegates that it does violate the platform it would seem desirable to so instruct the Society's Delegates to the American Medical Association.

Senate Bill 140, sponsored by Senators Fulbright and Taft, is similar to one introduced in last year's Congress. This would create within the Executive branch of the government, a Department of Health, Education, and Security, headed by a Secretary who would be a member of the Cabinet. The Secretary undoubtedly would be a layman. The Department would include three divisions: (1) health, (2) education, and (3) security. "The Under Secretary of Health shall be a doctor of medicine . . . . and shall perform such duties concerning health as may be *prescribed by the Secretary* or required by law."

This bill is in absolute contravention of the stated aims of organized medicine as repeated over and over again by the House of Delegates of the American Medical Association. We want to divorce health and welfare (social security) as governmental functions, and to place all health and medical activities of the Federal Government in a *single* agency—not in a multiple agency—concerned solely with public health; with the ultimate goal the establishment of a National Department of Health, headed by a physician with cabinet status.

A preliminary hearing on this measure was held before the Senate Committee on Expenditures in the Executive Department in February. We understood that full opportunity will be given for proponents and opponents of this measure to be heard. The Bureau of Legal Medicine and Legislation of the American Medical Association has already directed a communication to the Chairman of this Committee reiterating the position that the Association has taken for many years, namely that there should be created a Federal Department of Health in which all the proper health functions of the government could be coördinated and prosecuted. The view was expressed that such activities could not be adequately prosecuted in an executive department such as is contemplated by S. 140 in which there would be an intermingling of health, education, and security activities. The Association has asked an opportunity to present evidence before the Committee in support of these views.

PUBLIC RELATIONS

L. Samuel Sica, M.D., Chairman, Trenton

The preparation and release of the weekly *Health Hints* column has continued to be the major project of the committee. This column brings the name of The Medical Society of New Jersey before the public week after week and has proved to be an ethical and effective mechanism for earning public recognition for the Society. A constant stream of letters of inquiry coming mostly from rural areas, attests to the effectiveness of this project.

The weekly radio programs have been discontinued. We have already used all the electrically transcribed discs furnished by the A.M.A. and no new sets have been made available. Because of our inability to get enough doctors on a speakers' bureau, it has been found impossible to assemble a speaking staff for live radio programs. We have, however, assisted county and other local medical societies which operate programs on small stations by furnishing them with radio scripts.

The committee has prepared a "Publicity Guide for County Society Reporters" which is a manual of instructions explaining how to obtain good publicity for county society medical meetings. This Guide has attracted some attention outside the state. The Virginia Medical Society has asked permission to reprint it, characterizing it as the most practical presentation of its type they had ever seen, and a nationally circulated medical trade journal has also asked permission to reprint excerpts.

All efforts to set up a speakers' bureau have proved unsuccessful. It has been impossible to recruit enough physicians willing, on short notice, to give talks. Accordingly, we have had to let that function remain on a county society level, though the Trenton office continues to furnish speakers scripts, lecture outlines and often, on request, completely written talks.

The public relations office, through the year, proceeds in routine fashion to answer letters, prepare scripts, write weekly columns, handle correspondence and to keep up to date its library of talks and releases on scientific and economic topics. The program operates, however, in low gear, for the reasons already indicated. We have considered engaging a professional public relations counsel who could provide us with a dynamic program including inspired newspaper stories and editorials, photographic features, radio talks and a continuing public-speaking project. It was decided to withhold any recommendation on this until after a new Executive Officer has been selected, since it was felt that public relations would be so much a part of his work, that his views on the subject should first be solicited.

The Public Relations Committee serves as our Society's liaison with the State Health Congress. This unique organization is beginning to function and our committee is intimately associated with every step of its operations. Governor Driscoll and Dr. Clothier have agreed to serve as honorary consultants.

The Trustees have authorized a state health week for October 1947, and the Public Relations Committee shares with the Public Health Committee, the job of planning and operating that activity. Work on this has already begun.

Dr. Davidson, Executive Secretary of the Subcommittee has asked to be relieved of his duties as of April 30, 1947. When the Society obtains the service of a new Executive Officer, it will become possible to accede to this request though the Subcommittee relinquishes Dr. Davidson's services with regret and with the hope that he will continue to be available to us in an advisory capacity.

It is recommended that the Executive Officer of the Society be designated *ex-officio* Executive Secretary of the Subcommittee on Public Relations and that public relations activities hereafter be considered an integral part of the functioning of the Executive Office. This is in line with current organizational trends whereby the maintenance of good public relations is considered a prime function of any executive official.

PUBLIC HEALTH

Samuel Blaugrund, M.D., Chairman, Trenton

The Public Health Committee, during the past year, has operated on the basis that everything pertaining to the public health of our citizens is the direct responsibility of the medical profession.

It has been my observation, over the past few

years, that many organizations (other than medical) have been formed in the interest of public health, and in many instances on very constructive lines. However, all of these agencies interested in public health should have representation on their boards of directors and executive committees of members of the medical profession. It is also important that the medical profession itself assume the responsibility and leadership in guiding these various health agencies into sound public health programs.

With this in mind the Chairman of the Public Health Advisory Committees were asked to submit their immediate and long range plans of what constitutes good public health in New Jersey. It is with pride and deep appreciation to my Advisory Committee Chairmen and their members report that much has been accomplished in this field during the year.

One of the most constructive pieces of study to emanate during this period was the study and recommendations made to the Commissioner of Education of New Jersey for the improvement in the school child health services. There have been many other accomplishments and your attention is directed to the reports of the various Public Health Advisory Committees.

In conclusion, I stress again the importance of members of the medical profession of New Jersey assuming the responsibility for, and manifesting an active leadership in, public health in the state irrespective of what form it may take.

MEDICAL PRACTICE

Watson B. Morris, M.D., Chairman, Springfield

The Subcommittee on Medical Practice held four lively and well-attended meetings during the 1946-47 fiscal year. As the Subcommittee serves chiefly as a forum for presentation and analysis of the work of its advisory committees, the best report of our actions is found in the reports of these advisory committees. Members are referred to the reports of the following advisory committees: Anesthesiology (page 156); Contract Practice (page 157); Hospital Relationships (page 157); Industrial Health and Hygiene (page 158); Laboratory Medicine (page 159); Nursing and Nursing Education (page 159); Pharmaceutical Problems (page 159); Physical Medicine (page 160); and Workmen's Compensation (page 160). A review of these reports will give a kaleidoscopic picture of the work of the Subcommittee on Medical Practice for the current year.

PUBLIC HEALTH ADVISORY COMMITTEES

CANCER CONTROL

William O. Wuester, M.D., Chairman, Hillside

During the past year your committee has stressed constructive action in Cancer Control. A review of the accomplishments is in order. We set out with certain immediate and long range objectives in mind and the extent to which we have succeeded is indicated in this report.

THE PHYSICIAN'S ROLE

At the inception of our co-operative work with the American Cancer Society the laymen and medical men agreed that "it is the responsibility of the doctors to advise how, where and for what medical facilities, programs and services money shall be spent. It is the responsibility of the laymen to raise the money and administer the funds according to sound business practices." We thought that this was a wise decision and as long as we could keep this principle in mind, friction and misunderstanding would be avoided. Your committee has closely guided the development of various phases of the Cancer Control program as carried out by the American Cancer Society.

Toward this end there was appointed as Medical Director of the American Cancer Society, Dr. Leonid Snegireff, formerly of the Department of Health and a medical member

of our Advisory Cancer Committee, who represents The Medical Society in the Cancer Society headquarters. It is his duty to consider and approve all formal public statements pertaining to medical matters released by the American Cancer Society. This we felt was desirable to avoid any misunderstanding that might arise from misquotations in the public press. Dr. Snegireff has done an excellent job in coordinating the activities of the lay and medical groups and in advising these groups in regard to prospective cancer programs in the individual counties.

All county projects were first cleared through the Cancer Committee of the county medical society and then submitted for close scrutiny by this committee and, if necessary, re-written prior to the granting of approval. It is necessary to point out, however, that in a few instances your committee was at variance with the opinion of the county medical society's cancer advisory committee, but after thorough discussion with the local group such differences were minimized.

One of our main objectives was to make certain that no project would be approved which violated the principles set forth by the Board of Trustees of The Medical Society of New Jersey in regard to the practice of medicine.

NEW JERSEY SURVEY

A sum of approximately $2,000 was expended for a survey which brought to light that many of our cancer clinics already recognized by the American College of Surgeons were little more than paper organizations. This was primarily due to the fact that this survey was made shortly after the termination of the war and as yet these institutions had not sufficient time to re-organize. In the last year there has been a great deal of improvement. We felt that such a survey was essential so that we would have a starting point from which we could measure the accomplishments of expended monies by results obtained in the future. Toward this end we are instituting a monthly report program which will be submitted from each institution to which funds from the American Cancer Society have been allocated. These will be reported in full in future issues of the JOURNAL.

STANDARDIZATION OF CANCER CLINICS

To get some opinion as to what equipment was necessary for a cancer clinic, so that we would have a yardstick by which to approve expenditure of the funds of the American Cancer Society, we published in the September 1946 JOURNAL an article titled—"The Cancer Program in New Jersey, Part 1. Diagnostic and Therapeutic Cancer Clinics"—in which we fully described the organization of full time, part time and diagnostic cancer clinics. Subsequent to this your committee has enlarged upon the description of the type "C" or diagnostic clinic which would be acceptable to the Trustees of The Medical Society. Copies are available to those who desire them. Complete data as to organization and cost for the permanent equipment have been discussed in detail.

ADVISORY BOARD

This committee has been called upon, through its membership, to act as an Advisory Board to medical groups desiring to establish clinics within New Jersey. We have prevented considerable waste of funds by disapproving ill-advised projects. A real effort has been made to improve the cancer clinics that have been shown to be below par in the survey. The committees appointed by the county medical society have been publicized in the County Statistical *Bulletins*. Excellent cooperation was obtained from the president of each county medical society in the appointment of a cancer committee.

COOPERATION WITH THE PROFESSION

Through the efforts of the Cancer Committee and the Medical Director of the American Cancer Society an attempt has been made to encourage the lay public to seek complete examinations from their family physicians for the detection of cancer. News releases and publicity for the April campaign of the American Cancer Society were aimed to a large extent in this direction. It is the duty of the physician to cooperate. He will discover more cancer than all the clinics combined. The success of our program depends on a desire on the part of the patient to have a complete physical examination and/or *the willingness of the physician to perform the examination.*

Your committee has been in close touch with the New Jersey Society of Clinical Pathologists and has worked out a plan for a statewide tissue diagnostic service. This was fully described in the February 1947 issue of the JOURNAL of The Medical Society of New Jersey. The cost of the containers, printed forms and postage is borne by the American Cancer Society, New Jersey Division, Inc. Physicians were circularized by cards enabling them to request containers for their private practice.

The New Jersey State Department of Health will establish a tumor registry in which the New Jersey Society of Clinical Pathologists is closely cooperating. Through their

good offices and the establishment of this department it will be possible, in the future, for a physician interested in graduate work in the cancer field to obtain pathologic slides and complete case abstracts.

STATISTICAL RESEARCH

The American Cancer Society, New Jersey Division, Inc., with the cooperation of the medical and related professions, has made available the findings in a statistical research project. The statistics in each county are available. Copies may be obtained by writing to the American Cancer Society, New Jersey Division, Inc., 790 Broad Street, Newark 2, New Jersey.

MEDICAL PROJECTS APPROVED TO DATE

Up to March 1, 1947, the committee approved the expenditure of $235,000 of American Cancer Society funds for medical projects in New Jersey. Several additional projects are under consideration. The allotments by counties follow:

Atlantic County	$12,900.00
Burlington County	7,373.75
Camden County	13,390.00
Essex County	61,456.00
Gloucester County	54,200.00
Hudson County	26,123.20
Hunterdon County	4,054.00
Mercer County	13,555.00
Monmouth County	28,502.75
Ocean County	545.61
Passaic County	53,466.00
Sussex County	3,200.00
Union County	5,765.00

FUTURE PLANS

It is the aim of the committee to continue to publicize both the general practitioner's and the specialist's role in this program. Through appropriate press releases, similar information is being disseminated to the public, the emphasis here being on the family doctor's role. The complete examination has been stressed in all our work, and we are gratified at noting that the lead editorial in the February 1947 Journal of The Medical Society of New Jersey was devoted to that subject.

At present only one residency in malignant and allied diseases is available in our state, but it is hoped that several others will be developed soon.

Definite progress is being made towards the institution of graduate courses in the diagnosis and treatment of cancer.

Within the next year we hope to crystallize some action on the care of the terminal cancer patient. Along with the projects which have been mentioned above we will strive to improve the already existing facilities.

It is fitting and proper at this time for the committee to call to the attention of every physician the marvelous cooperation we have had from Mr. George E. Stringfellow, president of the American Cancer Society, New Jersey Division. Any words of praise which we might utter for his work would be inadequate.

Special words of thanks are also due to Dr. Emil Frankel, Research Consultant of the State Department of Institutions and Agencies and to Dr. Raymond W. Brokaw of the N. J. State Department of Health for their splendid cooperation with the committee.

CARDIO-VASCULAR DISEASE

Jerome G. Kaufman, M.D., Chairman, Newark

The chairman of the committee on cardiovascular diseases reports that his committee met and discussed the problems of cardiac patients. The committee decided that a survey be made of facilities for cardiac patients throughout the state. This was done and revealed that there are only 18 approved cardiac clinics in the state and only 35 available beds for long term care of cardiac children. There are no provisions for the long term care of adult cardiac patients.

It is evident that a program will have to be instituted to improve facilities for the study and treatment of cardiac patients. Plans are being formulated to send a speaker into each county in cooperation with the county medical society as a stimulus and educational program.

The chairman of the committee has also prepared a detailed program dealing with the detection of sick children by the school room teacher, who will refer them to the school nurse or physician for proper classification and direction. The program also includes an outline for the teaching of the common medical diseases, such as rheumatic fever and tuberculosis, in grammar and high schools. The program is to be submitted to Dr. W. G. Guthrie for transmission to the State Board of Education.

CHILD HEALTH

Stanley Nichols, M.D., Chairman, Long Branch

In June, 1946, the Child Health Committee adopted as a long range program five greatly overdue needed improvements in the field of Child Health as follows:

(1) An improved school health program.
(2) A program for the improvement of neonatal mortality.
(3) Rheumatic heart disease control. This is the greatest single cause of death in school children, except accidents.
(4) A good mental hygiene program for children.
(5) Better medical care for children in low income families.

SCHOOL HEALTH PROGRAM

Dr. Blaugrund, Chairman of the Public Health Committee, has selected this as the major effort of that Committee for the year, and much progress has been made during the year with the School Health Committee under the Chairmanship of Dr. Harold Tidwell and with the aid of consultants Dr. Wilson Guthrie, Miss Lulu Dilworth (Chief and Associate Chief of the Division of Health and Physical Education of the State Department of Education), and Dr. Harold Mitchell (Chairman of the School Health Committee, American Academy of Pediatrics). Dr. Blaugrund will report more fully on the progress to date.

NEONATAL MORTALITY

Our Committee, with the aid of Dr. Chester Brown, Chairman of our Subcommittee on Newborn, is again carrying forward this program with the aid of the Maternal Welfare Committee under the Chairmanship of Dr. Robert A. MacKenzie and consultants Dr. Julius Levy, Dr. Esty and Dr. Weigel of the Bureau of Maternal and Child Health, State Health Department. The chief objective at this time is to develop joint services for the newborn by the obstetrical and pediatric staffs in the hospitals of the State.

RHEUMATIC HEART DISEASE

This public school child enemy number one is beginning to get a degree of the attention it has always needed, and Dr. Blaugrund's Subcommittee on Rheumatic Fever, with consultants Dr. William Rumsey (Director of Rheumatic Heart Disease of the New Jersey Crippled Children Commission) and Dr. Jerome Kaufman, Chairman of the Cardiovascular Advisory Committee, are attacking this disease on two fronts. (1) An educational program to acquaint the professions and the public with the seriousness of this disease, which is being materially aided by the present National Heart Week and drive for funds put on by the National Heart Council. (2) The actual rheumatic heart disease program, initiated by Vice-Chairman Harrold Murray of our Child Health Committee and Chairman of the New Jersey Fellows of the American Academy of Pediatrics, is financed by the New Jersey Crippled Children Commission. The chief unit of this has been operating this year in St. Michael's Hospital, Newark, and two more units are being planned in other parts of the State for the near future under the direction of Dr. Rumsey.

MENTAL HYGIENE PROGRAM

Dr. Edward P. Duffy, Jr., Chairman of our Subcommittee on Mental Health, with the aid of consultants Dr. Henry Cotton, Jr., and Dr. G. W. Esty, have begun an educational program in several places in the State. These are being expanded by the fine program of mental health education for the several hundred nurses and physicians attending the Baby Keep Well Stations of the State Department of Health,—developed by Dr. Julius Levy, Dr. Esty, and Staff of the Maternal and Child Health Division, State Department of Health. Further expansion is coming about as the result of the gradual development of the Mental Health Program being developed under the Chairmanship of Dr. Henry Cotton, Chairman of the Mental Hygiene Committee of the State Society. The Child Guidance Clinics developed by the State Department of Institutions and Agencies, and those in some of our large cities, are of great importance in this much needed expansion of better mental health training for children and their parents.

LOW INCOME FAMILIES

Because of the rising cost of living in recent years, as well as a similar rising cost of health services, this important matter needs study and action on the part of every member of The Medical Society of New Jersey. A great deal of light will be thrown on the subject when the State Child Health Survey of the American Academy of Pediatrics is presently completed, under the Chairmanship of Dr. Harrold Murray. The New Jersey commission on Hospitals and Health Centers, recently set up with funds from the Hill-Burton Law, will plan Child Health Centers to meet some of this need. The Taft-Smith-Ball Bill, recently in-

troduced in Congress, will, if passed, be aimed at this same problem of low income families' medical and dental care. It will necessitate a state setup similar to the one in Maryland to carry out its provisions. Finally the New Jersey Health Congress, a project sponsored by the Public Relations Committee of our Society, is beginning "A study of the quality, quantity, availability, and distribution of professional health services in New Jersey", and its recommendations will be of considerable assistance in this field, as the Congress is composed of those who render this service (the health professions), those who receive these services, and the State Governmental Agencies interested in health services.

This matter of providing the best possible medical care for the children (and adults) in low income families is the paramount problem facing the medical profession today, and a wise solution can only be reached if every member of The Medical Society of New Jersey, not only renders good medical care to his own patients, but also feels that he has a definite responsibility to see to it that every man, woman, and child in his community receives good medical care. Now that the war is over, this must be the immediate objective of organized medicine, as otherwise governmental medicine will blanket the whole population and political control, unworkability, and lowered standards of medical practice will create types of medical care, which will be no credit either to governmental or medical agencies. Governmental and medical agencies still have a limited time to voluntarily develop good quality medical care through cooperative teamwork and effort and the focus of this effort must be to solve the problem of low income families. Collectively as an organized medical profession, we thus have the opportunity to do what our medical forebearers did individually, namely to solve all of the health problems of all of the people in all of the communities of New Jersey.

We estimate that these five child health needs, on all of which a good beginning has been made, will require a period of years for full development, and we ask the wholehearted assistance of all State and County Society Committees and all members, so that The Medical Society of New Jersey may continue to make progress on these our contributions to the health needs of New Jersey's children.

CONSERVATION OF VISION AND HEARING

Elbert S. Sherman, M.D., Chairman, Newark

The Committee met on October 6, 1946. Several matters, which had been referred by Subcommittees of the Public Health Committee and by State Agencies, were discussed and acted on.

In accordance with the request of the Subcommittee on Public Health for suggestions for improving the proposed health program for the public schools, recommendations were made concerning the detection of impairment of vision and hearing and other eye and ear defects. Also, a state-wide program was suggested for the education of the public, including school teachers, nurses and others, in matters pertaining to the conservation of vision.

The project of a mobile eye clinic for work in rural areas, sponsored by the New Jersey Junior Women's Clubs and supervised by the New Jersey Commission for the Blind, was approved. The clinic is now in operation.

The Committee recommended approval of the objectives of the proposed program of the State Department of Health for Industrial Sight Conservation.

At the request of ophthalmologists in different communities, the Committee has been successful during the past year, in limiting the activities of certain optometrists in prescribing glasses for school children.

CRIPPLED CHILDREN

H. E. Reading, M.D., Chairman, Paterson

The Committee has continued its routine work, but nothing of sufficient novelty has developed during the year to warrant special reporting.

MATERNAL WELFARE

Robert A. MacKenzie, M.D., Chairman, Asbury Park

Meeting early in the summer at the home of the new Chairman, the members of the Committee with remarkable unanimity of feeling agreed:

1. To continue efforts to maintain a high standard of obstetrical practice in New Jersey, aiming particularly to eliminate preventable maternal deaths.
2. To study obstetrical responsibility for the persistently high rate of neonatal deaths, and join with the Child Health Committee in efforts to reduce this rate.
3. To consider the problem presented by new "hospitals" which are often privately owned institutions offering maternity care of unknown quality without check or supervision.
4. To aid in providing facilities for much needed postgraduate training in obstetrics.

Many years ago this Committee formulated and distributed with the endorsement of the state society officers "Rules" for good obstetrical practice. These indicated minimum standards in the conduct of labor and delivery and urged consultation in all complicated cases. The present Committee thought it well to alter the suggested practices somewhat under the title "Procedures". Under the seal of the Society these again have been sent to all hospitals and maternity homes. It is gratifying to note that in 1946 the rate of maternal mortality in New Jersey was approximately 1.2 * per thousand live births, a figure slightly lower than recent years, materially different from the 3.7 of ten years ago. But it is unhappily true that the majority of mothers lost could almost certainly have been saved by more conscientious management and expert judgment. In working toward further improvement the Committee places much dependence upon the Field Physicians who are appointed by the County Societies and work in liaison with the Bureau of Maternal Health of the State Department of Health.

This group of enthusiasts, many of whom have a record of many years of loyal service, not only report conditions in their districts but also aid in directing local maternal welfare activities. Partly through their efforts hospital staff meetings hear reports of the work of the maternity departments and most county societies arrange at least one program of obstetrical interest in each year. In the larger counties maternal welfare committees meet regularly to review maternal deaths, assign responsibility for each tragedy and try to prevent a similar happening. In December a joint meeting of these Field Physicians with the State Committee in Newark produced interesting discussion and a number of valuable suggestions. Members of the county maternal welfare groups, were also invited to this meeting and all counties were represented except Cumberland, Gloucester, Middlesex, Ocean, Salem and Warren. Included in the fifty eight doctors who attended the two hour afternoon conference, were all eight members of the State Committee and twelve Field Physicians. The same group will meet again during the Convention in Atlantic City.

Reduction of fetal loss is an important goal to which the Maternal Welfare Committee logically now turns as its second goal. Much work has been done and is being carried on by the Child Health Committee toward improving newborn care, urging breast feeding and stressing precautions in care of prematures, etc. Upon the doctor attending women in labor, however, rests the greatest responsibility for the condition of newborn infants especially those of immature development and those weakened by toxemia or hemorrhage in the mother. Accurate evaluation of factors contributing to stillbirths and deaths of babies in the first days of life, can only be accomplished after detailed case study and postmortem examination. But survey of figures reported each year to this Committee can be valuable. The efficient Bureau of Maternal and Child Health is preparing comparative statistics showing fetal loss, incidence of operative delivery, maternal morbidity and other data for hospitals having approximately the same equipment and number of deliveries.

This study covers the two year period 1945 and 1946. Significant variation in results is already evident. It is planned to refer an abnormally high rate of interference and high fetal mortality to the hospital authorities and the Medical Society Committee of the county concerned. The willing assistance of the Bureau of Maternal and Child Health in all matters has been inspiring to this Committee.

With the well organized institutions generally holding to conservative obstetrics there is contrasting radicalism by doctors in small hospitals throughout the State. It is realized that there are explanatory circumstances, patients in rural counties being delivered more often at

* Statistics in detail will be published in a later issue of the Journal.

home except in event of complications. In some counties lack of accommodations in well equipped hospitals forces denial of courtesy privileges to many doctors. Unable to deliver their patients in a well supervised institution these doctors use less satisfactory places and have complete freedom of action. Licensing of small private hospitals seems not to be conditioned upon proven or probable ability of the proprietor or staff to offer quality service. The Maternal Welfare Committee called this matter to the attention of the State Society at the September meeting of the Welfare Committee and the problem was referred to the Committee on Hospitals. There is this serious weakness in the program of guided obstetrics with compulsory consultation which is the main strategy in the fight for safer motherhood.

Another unsolved difficulty is the serious shortage of facilities for graduate training in obstetrics. Interest in obstetrics appears to be increasing and a large number of young doctors express desire for training to supplement that obtained in their rotating internship. Residencies of any kind are far too few. The University Hospitals have discouragingly long programs of resident training. Many of the general hospitals in New Jersey are eligible for one or more obstetrical residencies. It is hoped that they will take steps to help fill the need for special training, of enthusiastic young practitioners of whom our state will be proud.

Prospective formation of a New Jersey Obstetrical and Gynecologic Society offers hope for valuable informal instruction. Encouraged by the Maternal Welfare Committee the plans will be presented before the next Section meeting in these specialties. Membership requirements will be liberal and the projected twice yearly conferences should be helpful.

MENTAL HYGIENE

Henry A. Cotton, Jr., M.D., Chairman, Trenton

Two meetings of the Committee were held during the year. The following points were emphasized at these meetings:

1. *Education of the Public*—It was felt that the public needed more information regarding mental hygiene and psychiatry. Most of the other medical specialties are far ahead of psychiatry with regard to public education. It was felt that this could be accomplished through: (a) periodic press releases; (b) talks before lay groups; (c) pictures and pamphlets; (d) radio programs.

2. *Education of the Medical Profession*—It was felt that this could be accomplished by having at least one speaker on psychiatry and mental hygiene for every County Society during the year. Refresher courses in Psychiatry for general practitioners might also be started at a later date.

3. *Medical Leadership*—Mental Hygiene is primarily a medical problem and while lay groups can be of value, their activities should be controlled by physicians. To accomplish this, it was recommended that the members of the Committee make an effort during the year to influence as many lay groups as possible, so that the medical profession may retain the leadership in this field.

4. *Alcoholics*—Mental hygiene services for alcoholics in this state need to be studied, with a view toward making recommendations for the handling of the problem.

5. *Psychiatric and Mental Hygiene Services in General Hospitals*—There is a real need for expansion of such facilities in general hospitals throughout the state. This would take some of the load from the traveling state clinics and also offer an inducement for more physicians to take up the specialty of psychiatry in private practice. It was felt that each large and moderate size hospital should include a psychiatric service on the same basis as the various other medical specialties. There are, of course, certain objections to having in-patient services but at least consultation and outpatient facilities could be maintained.

ACTION TAKEN

1. On December 17, a press release was put out with the approval of the Public Relations Committee of The Medical Society of New Jersey. This stressed the need for early diagnosis and treatment and recommended more psychiatric service in general hospitals as a means toward accomplishing this end. The release also called attention to the overcrowding which presently exists in the various state and county mental hospitals. It further called attention to the need for additional personnel in the mental hospitals and indorsed the action of the Department of Institutions and Agencies in establishing a new position with the title of Psychiatric Technician to improve the professional service in state and mental

hospitals. This release was given wide and favorable publicity by the press of the state.

2. A letter was sent over the signature of the President of the Society, recommending the establishment of more extensive mental hygiene and psychiatric facilities in general hospitals and the date has been set for a meeting with the officials of the Hospital Association—Drs. Scammell, Schaaf and representatives of the Mental Hygiene Committee. Dr. George S. Stevenson, Medical Director of the National Committee of Mental Hygiene and, by virtue of residence in New Jersey, a member of the Mental Hygiene Advisory Committee, is also planning to attend this meeting.

3. A letter was sent to the President of The Medical Society of New Jersey recommending that each county society be advised to include at least one program during the year on mental hygiene and psychiatry.

4. A refresher course in psychiatry for general practitioners was started in Essex County through the efforts of Dr. Lewis H. Loeser, a member of the Committee. This course consists of fifteen, two-hour sessions held weekly, commencing February 18.

5. Talks on mental hygiene were given by your chairman to various groups, such as Kiwanis, Rotary, Lions Clubs, etc., in Trenton, Camden, Atlantic City, Paterson and Newark. Similar talks have also been given by other members of the Committee.

6. Your chairman has communicated with the National Mental Health Foundation in Philadelphia regarding the publication of literature on mental hygiene suitable for distribution among lay groups. Plans have also been made for a moving picture to instruct the public along this line. The National Mental Health Foundation has worked up a number of radio broadcasts for public instruction and in cooperation with this Committee such broadcasts have been made over several stations in New Jersey.

7. Your chairman met with Governor Driscoll in his former capacity as Commissioner of Alcoholic Beverages and other members of the Commission to study the problems of alcoholism in New Jersey. A conference was also held with Dr. Lyman Duryea, Medical Director of the National Council on the Research Problems of Alcoholism in New York. Meetings have also been held with representatives of Alcoholics Anonymous and your chairman participated in a radio broadcast with members of Rutger's University on the problem of alcoholism in New Jersey.

8. As part of a plan to bring psychiatry closer to the general practitioners, meetings of the Mercer, Morris and Monmouth County Medical Societies were held during the year at the State Hospitals at Trenton, Greystone Park and Marlboro respectively.

Your chairman has attended a number of meetings of the Subcommittee on Public Health and in cooperation with Doctors Blaugrund, Guthrie and Stanley Nichols a plan has been worked out for the expansion of psychiatric and mental hygiene service in the public schools. A recommendation was made to and adopted by the Subcommittee on Public Health for a psychiatrist to be placed on the staff of each county superintendent of schools.

10. In order to develop a coordinated mental hygiene program throughout the State, your chairman has met on several occasions with representatives of the Departments of Health and Education.

NUTRITION

S. WILLIAM KALB, M. D., Chairman, Newark

The general practitioners and specialists in all fields have become nutrition conscious in recent years. The JOURNAL of our medical society is probably the only state journal which devotes a page each month to acquaint the doctors with the scientific problems of nutrition.

Our committee has been working in cooperation with the State Nutrition Council, the Nutrition Foundation, and the Nutrition Committee of the Red Cross.

We participate in symposia on nutrition with the Woman's Auxiliaries of the county medical societies.

Courses are being given on maternal and infant nutrition to expectant mothers by the American Red Cross with the cooperation of our Committee through the local county societies.

Universities and colleges are being solicited to use their influence in requiring nutrition and health courses as prerequisites for entrance to the freshman year.

We are arranging symposia on nutrition for groups including dentists, nurses and pharmacists.

Programs are being formulated to have panel

discussions by prominent nutritionists before each county medical society.

The committee acts in an advisory capacity to the Restaurant Asspciation, and various food manufacturing plants.

We are submitting material on nutrition for the layman to be published in foreign language newspapers and periodicals throughout the state.

The chairman of your committee has testified before the Solicitor General in Washington on behalf of the Food and Drug Division of the Government against various nostrums.

It is the aim of this committee to make available to the doctors all information on foods and drugs which are used in various deficiencies; and to take the subject of nutrition out of the hands of the fadists and the radio commentators and put it on a scientific plane where it belongs and where it can be made useful to all.

I want to thank the members of the committee and the editorial staff of the JOURNAL for their cooperation during the past year.

SCHOOL HEALTH

HAROLD F. TIDWELL, M.D., Chairman, West New York

A full meeting of this committee has not been held, but most of the members are familiar with the recommendations. The original report submitted to the Public Health Committee was the one which had been submitted to the New Jersey fellows of the Academy of Pediatrics. Reports have been made at subsequent meetings of the Public Health Committee. The pertinent suggestions for improving the health program in the Public Schools of New Jersey are as follows:

1. Strip to the waist examinations.
2. Compiete examinations on admission, the 4th grade, the 8th grade and the 12th grade, with the parent present whenever possible.
3. Each County Superintendent should be required to add a psychiatrist to the school system.
4. Compulsory vaccination against smaiipox and immunization against diphtheria, with a recent negative Schick Test.
5. All school teachers and adult school personnel should be x-rayed for tuberculosis every year. (Every third year at present.)

Through cooperation with the State Department of Education it is hoped that state-wide standardization of records and procedure might be instituted, also cooperation with other interested agencies to formulate aggressive health measures in the preventive pediatric field, and other measures conducive to better health in the school system.

Generally speaking, this would cover subjects such as rheumatic fever, eye and ear defects, mental hygiene, crippled children, tuberculosis, standards for nursing and medical personnel, and the role of the family physician in school health administration.

TROPICAL DISEASES

CHRISTIAN P. SEGARD, M.D., Chairman, Leonia

The past year has borne out previous predictions regarding the spread of tropical disease with one exception: malaria.

While other tropical diseases have remained under control, reports indicate that new cases have appeared when a relapsing case has domiciled in an area where the mosquito vector is present.

Postwar tropical diseases are under control through grant-in-aid from the American Foundation for Tropical Medicine and through Army and Navy Tropical Disease Centers. A few cases have come to the attention of the State Board of Health and civilian physicians. All such cases should be referred to the establishment especially set up for veterans.

The Committee will continue to abstract papers on tropical diseases for publication in the JOURNAL.

TUBERCULOSIS

ABRAHAM E. JAFFIN, M. D., Chairman, Jersey City

The Advisory Committee on Tuberculosis has undertaken a comprehensive program this year, covering many problems furthering the latest procedures and technics in the elimination and prevention of tuberculosis.

We are at present actively engaged in advocating the following:

1. X-raying all hospital admissions and clinic cases routinely.
2. Organization of community surveys.
3. Importance of "contagious technic" in mental and general hospitals.
4. Central registry.
5. Routine tuberculin testing in schools.
6. X-raying all school children.
7. Annual radiologic surveys in schools for personnel, as well as for students.

Attendance at regular and special meetings has been almost one hundred per cent.

From a public health standpoint this Committee speaks with authority in its field. We hope to maintain the high standards that New Jersey holds in anti-tuberculosis work. We were pioneers in introducing mass surveys in schools and colleges. We undertook pre-induction services for the Armed Forces in the last war before the nation was equipped to do so. We have endeavored to act as an advisory body to the Public Health Committee in every way that we know of regarding measures within our field. We therefore earnestly hope that our recommendations, after they are approved by the Public Health Committee, meet with broad and sympathetic understanding by the Welfare Committee so that they can be made effective.

VENEREAL DISEASE CONTROL

ROBERT LEWIS MCKIERNAN, M.D., Chairman, New Brunswick

The Advisory Committee on Venereal Disease Control of The Medical Society of New Jersey held a meeting on November 13, 1946, at New Brunswick.

The recommendations which were submitted to the Sub-Committee on Public Health are the following:

1. The teaching of sex hygiene should become a regular function of the school system of New Jersey.
2. That better reporting of contacts and sources of infection of venereal disease by the general practitioner to the State Department of Health be strongly recommended.
3. To have a Venereal Disease Control Section on the program at the State Medical Society's meeting this year.
4. That the State Department of Health supply P.O.B. to all physicians of New Jersey and two 10 cc. vials equivalent to 6,000,000 Oxford units of penicillin for the treatment of early syphilis of not more than one year's duration. This is to be given to the physicians free of cost, provided that the case shall be interviewed by the state nurse or the investigator to determine the contacts and sources of infection. No patient will be interviewed without the knowledge of the physician.
5. A diagnosis of syphilis shall not be made on serologic evidence alone, unless two Mazzini tests taken not less than two weeks apart are both four plus.
6. That the New Jersey VD Clinic Physicians Association with a membership of 120 physicians become a part of The Medical Society of New Jersey. Since its formation in January 1945 its association has been a constructive adjunct to the Bureau of VD Control and to the State Department of Health of N. J.

Recommendations No. 4 and 5 are strongly urged from the N. J. State Department of Health and should be so recommended by the State Society after proper consideration.

At the meeting of the Subcommittee on Public Health, January 12, 1947, at Trenton, the following was reported:

1. *Teaching of sex-hygiene in the school system of New Jersey.*

In the discussion the following suggestions were made: that the course to be offered be given some other name, such as Education for Family Life; that local school districts work out their own course of instruction, the subject matter to be under supervision of The Medical Society of New Jersey; that the subject be resolved on a local level; that there be included in the program the training of students in the State Teachers' Colleges.

Upon motion it was directed that the matter be left in the hands of Dr. McKiernan and Dr. Guthrie of the State Department of Education.

2. *That there be recommended better reporting of contacts and sources of infection of venereal disease by general practitioners.*

Upon motion, seconded and unanimously carried the above recommendation was approved.

3. *A Venereal Disease Section at the State Society Annual Meeting.*

Upon motion the recommendation was referred to the Annual Meeting Committee.

4. *That the New Jersey Venereal Disease Clinic Physicians Association become a part of the Medical Society and be recognized as such.*

Upon motion, seconded and unanimously carried, the above recommendation was referred to the Board of Trustees for disposition.

5. *That the Department supply P.O.B. to all physicians in New Jersey for treatment of early syphilis of not more than one year's duration.*

Following discussion relative to the principle of supplying P.O.B. free to physicians for use in treating all venereal disease cases regardless of the ability of the patient to pay, it was moved that the matter be referred to the Welfare Committee without recommendation from the Public Health Committee. Seconded and unanimously carried.

6. *That a diagnosis of syphilis not be made unless two Mazzini tests, taken not less than two weeks apart, are both four plus.*

At the meeting of the Board of Trustees on Sunday, January 26th approval was given to recommendations numbered 2 and 6.

The following recommendation from the Welfare Committee was disapproved:

That the New Jersey Venereal Disease Clinic Physicians Association become a part of the Medical Society and be recognized as such.

In the conference which took place January 12th, 1947, with Dr. Frank Scammell, Dr. Royal Schaaf, Dr. Harrold Murray and Dr. Robert L. McKiernan, a Venereal Disease Section was authorized.

I wish to take this opportunity in extending my thanks to all the members of the committee for their cooperation, to the Welfare Committee, to the Subcommittee on Public Health of which Dr. Samuel Blaugrund is Chairman, to the Board of Trustees of the State Society and to Dr. Frank Scammell, Dr. Royal Schaaf and Dr. Harrold Murray for their cooperation and support.

It is my earnest hope that definite action will be taken on the matter of sex hygiene, the distribution of P.O.B. to the Physicians of the state, and that the federal funds which were withdrawn in December 1946 for VD Control, will be restored to the states since this problem was not one of state wide significance but of national importance. Too much emphasis cannot be placed on such an important problem.

MEDICAL PRACTICE ADVISORY COMMITTEES

ANESTHESIOLOGY

H. G. Walker, M.D., Chairman, Wyckoff

The Advisory Committee on Anesthesiology during this initial year of its existence has spent much of its time in organization of the practicing Medical Anesthetists in our State. Therefore our report for the year can well be called a "progress report".

One outstanding accomplishment of the committee has been the forming of the "New Jersey State Society of Anesthesiologists". The membership in the latter society is state wide and includes only members of "The Medical Society of New Jersey" practicing anesthesia.

After due consideration based upon state wide opinions of anesthetists, the committee believes that further investigation is necessary before making any recommendations.

It is interesting to note that the complaints of the few abuses in the practice of anesthesia are identical throughout the state. A few well considered measures of control will correct the now existing abuses and make for better anesthesia.

However the committee does recommend that the Specialty of Anesthesiology be granted a "Section on Anesthesiology" in The Medical Society of New Jersey.

The committee is cognizant of the recognition accorded the specialty of anesthesia and has appreciated the opportunity to serve.

CONTRACT PRACTICE

Andrew C. Ruoff, M.D., Chairman, Union City

This committee functions at the call of the president, or at the call of the Medical Practice Committee.

No matters were referred to the committee throughout the past year. Its chairman, however, attended the meetings of the Subcommittee on Medical Practice, and partook in the deliberations of that committee.

The fact that we were not called upon to pass on any disputed claims, would speak for a healthy condition in connection with matters that have to do with contract practice.

HOSPITAL RELATIONSHIPS

Herschel S. Murphy, M.D., Chairman, Roselle

The committee has studied the action of The Medical Society of New Jersey in previous years recommending that there be medical members on the Board of Trustees of the various hospitals and this committee agrees with the Medical Society in this matter.

In October the president of The Medical Society of New Jersey appointed the members of the Hospital Relationships Committee to act with a committee of the New Jersey Hospital Association to work on an extensive study of the intern situation as it affects New Jersey hospitals.

There are many more approved internships in both general hospitals and in Army and Navy hospitals than there are graduating physicians to fill the demand.

The deans of the medical schools of New York and Philadelphia together with the dean of the Graduate School of the University of Pennsylvania and others were contacted in regard to improving the standards of the New Jersey hospitals.

We found there were two types of general hospitals approved for intern training in New Jersey. The ones inspected and approved by the American Medical Association were general hospitals of 100 beds and over; and hospitals of 75 to 100 beds inspected and approved by the Board of Medical Examiners of New Jersey.

It was felt that the intern training standards of the hospitals in New Jersey, particularly of the smaller ones, must be raised so that more will apply to our hospitals for their training.

We discussed the plan of having larger hospitals accept interns and residents and then send them to the smaller hospitals for part of their special training and specialty work just as student nurses are "farmed out" to hospitals for special training. The committee thought that this was an excellent idea. Further phases of the intern training problems have been discussed at recent subcommittee meetings.

Due to the magnitude of the problem, it was thought wise at this time to recommend that internships follow out the present pattern of a one or two year rotating internship and that a manual for interns setting up proper standards be put out by the New Jersey State Board of Medical Examiners similar to the *Hospital Intern Year,* Bulletin No. 625 of the Pennsylvania State Board of Medical Education and Licensure.

A special committee has been appointed by the Association of American Medical Colleges and the American Medical Association to formulate standards for improved intern education. This study is being made and Dr. Jean A. Curran, dean of Long Island Medical College, who is chairman, informed me that its report will not be available for some time.

Our committee wishes to present this progress report and recommend that a Joint Committee be continued to make further study and recommendations during this coming year. No doubt it will take several years to work out a well correlated plan.

INDUSTRIAL HEALTH AND HYGIENE

J. Mallory Carlisle, M.D., Chairman, Westfield

During the past year, the Committee on Industrial Health and Hygiene has continued most of its previously instituted regular activities designed for furtherance of the physical welfare of workers in industry. It has been active in attempting to combat any slackening of standards such as may so readily occur in a postwar period. The smaller industries have been encouraged to seek the aid of physicians interested in occupational medicine for full or part-time services in order to meet most effectively the obligation of providing competent medical care to those injured or made ill in the course of their work. At the same time, the larger industries which have well organized medical services, have been urged to maintain them at a high peak of professional, competent service.

In cooperation with The Medical Society of New Jersey and neighboring areas, the Committee has continued to aid physicians, particularly returning veterans, in obtaining suitable employment in industry. In making such placements, it has also been the aim to make clear to the physician his obligation and the nature of his duties in order that he may carry them out most effectively and with the greatest benefit to both employer and employee.

Education of both physicians and nurses has been sponsored through the continuation of courses in industrial medicine and the encouragement of post-graduate training in those fields which are applicable to occupational medicine. In addition, lectures have been given both by those engaged in occupational medicine in New Jersey and by various specialists who have consented to appear before interested groups of physicians and present their particular aspect of the field.

Serious consideration has been given to the problem of providing undergraduate training in occupational medicine. Members of the Committee have served on the teaching staffs of nearby medical schools where every effort has been extended to increase the scope of undergraduate instruction in occupational medicine. Provision has been made in several of the larger industries in New Jersey for on-the-job training, somewhat in the nature of internships for qualified graduates interested in this specialty. No degree of didactic training, desirable though it may be, can take the place of actual clinical experience in this specific field. It is only in this way that the many relationships between the employer, employee and physician may best be understood and made more harmonious. This development of internship, on-the-job training is still very new as applied to this field but it can and should be developed greatly. The industries in New Jersey are ideal for the purpose because of their real need for medical assistance, and the varied nature of these needs, as well as their accessibility to nearby educational institutions. All concerned cannot help but be benefited by wide extension of such programs.

The objectives and plan of action submitted by the Industrial Sight Conservation Program of the Division of Adult and Industrial Health of the State Department of Health have been approved by your Committee. We have supported this program to date, and have made possible its presentation directly to the accredited organization of physicians interested in the health of the worker.

In furtherance of the aim of placing employees with arrested tuberculosis in work compatible with their physical condition, more thorough consideration has been given to the criteria to be used in evaluating such workers and in selecting suitable work stations for them. Through close cooperation with the Advisory Committee on Tuberculosis, we have vigorously supported the efforts designed to detect tuberculosis in its earliest stages.

An active part has been taken by the members of the Committee in the organization of the American Academy of Occupational Medicine which numbers among its charter members, several physicians now active in this field in the State of New Jersey. The objectives of this Academy are:

> The improvement of health of industrial workers, with improvement in occupational efficiency as a corollary, broadly construed to include cooperation with acceptable agencies that may further either directly or indirectly the physiologic well-being of the employed population.
>
> To this end, prevention, diagnosis, treatment and general care of occupational illnesses or injuries will be fostered. Research directed toward a better understanding of the pathogenesis of industrial diseases and improvement in methods of prevention and care will be instituted and encouraged.
>
> The results of these scientific investigations, as well as instruction in the causes and effects of occupational illnesses and injuries, will be made available to all interested agencies, groups, and individuals in a form suitable to their needs and capacities, so that the knowledge may be used in the best interests of the workers.

The Academy will take an active part in the education of medical, nursing, and technical personnel in the field of occupational medicine. A constant effort will be exerted to raise and maintain at a high level the professional standards of occupational medicine.

The Academy has aroused great interest among members of the medical profession in New Jersey and it is expected that its standards will serve as a goal for Departments of Occupational Medicine in industry and will thereby further improve practice of this specialty.

LABORATORY MEDICINE

ASHER YAGUDA, M.D., Chairman, Newark

At its inception last year the Advisory Committee on Laboratory Medicine expressed as its aim, "the institution of activities which will place the practice of laboratory medicine in its rightful position as a specialty of the practice of medicine".

In furtherance of this aim, the committee submitted a series of resolutions to the subcommittee on Medical Practice. These resolutions were published in the July JOURNAL and met varying fates at the hands of the Board of Trustees. That some progress has been made in line with our aspirations is evidenced by the recent action of the Trustees calling the attention of the New Jersey Hospital Association to the fact that anesthesiology, radiology, physio-therapy and clinical pathology are branches of the practice of medicine and that exploitation of these medical services by hospitals and hospital plans violates the principles and ethics of the American Medical Association.

It is hoped that the Committee will in the future:

(1) Continue its efforts to obtain the establishment of a Section on Clinical Pathology.
(2) Bring about some definite action, either in the interpretation of the present medical practice act by the Board of Medical Examiners or by the revision of the medical practice act to abolish or control the practice of clinical pathology by lay persons.
(3) Continue its fight against the encroachment upon the field of clinical pathology by the public health services.
(4) Encourage cooperation between the State Board of Health and clinical pathologists to the mutual benefit of both and the public we serve.

NURSING AND NURSING EDUCATION

A. CHARLES ZEHNDER, M.D., Chairman, Newark

During the past year this committee considered the Proposed Revision of the New Jersey Nursing Practice Act. After thoroughly studying the new act and suggesting minor changes, which were readily accepted and incorporated in the new act by the New Jersey State Nurses Association our Committee indorsed the Revised Act and advised the Medical Practice Committee that we recommend the approval of the Proposed Revision of the New Jersey Nursing Practice Act.

PHARMACEUTICAL PROBLEMS

CHESTER I. ULMER, M.D., Chairman, Gibbstown

It is planned to publish a fifth edition of the *New Jersey Formulary* this year. The last one appeared in 1941. In the new edition will appear some formulas recently developed at the Rutgers University College of Pharmacy with funds contributed jointly by the Medical Society and the New Jersey Pharmaceutical Association.

Complying with the recommendation of the Council on Pharmacy and Chemistry of the A.M.A., both metric and apothecary systems will be used for indicating dosages. Emphasis will be on the metric system and secondary consideration given to apothecary symbols.

It is our feeling that the fifth edition of the *Formulary* will be well received by the physicians of the state and that they will find the formulas of practical value and use.

Practically all of the revision work on this edition has been done by Dr. Tom D. Rowe, Dean, Rutgers University College of Pharmacy. We are indebted to him.

It is with great regret that we record the deaths of two members of the Committee, Drs. Reeve Ballinger and Daniel F. Remer. Dr. Ballinger had been a member of this Committee for many years and contributed a great deal of his ability and enthusiasm to the work. He was popular with the pharmacists and was a speaker at their last convention in Atlantic City. Dr. Remer also died during the year. He had a genuine interest in the activities of the Committee. Dr. Victor G. Haury moved out of the State.

Recently Dr. Albert B. Kump, a member of our committee, was made chairman of the Joint Committee on Professional Relations. He is doing splendid work for the joint cause of medicine and pharmacy.

To complete the personnel of the Committee, three new members have ben appointed: Dr. Anthony J. DiIelsi, Camden County; Dr. Louis C. Schneider, Essex County; and Dr. John L. Varriano, Hudson County.

PHYSICAL MEDICINE

Bror S. Troeddson, M.D., Chairman, Orange

The long-range program of this Committee embraces two essentials: first we would like to see in every hospital in New Jersey a properly supervised and equipped Department of Physical Medicine. Medical knowledge and training being the first pre-requisite for proper care of patients, these departments would be in charge of physicians with special training in physical medicine, and not be nominally in charge of a roentgenologist, an orthopedic surgeon, or an internist. Neither the patient's best interest nor the hospital's nor the profession's are served by such an arrangement. The Committee has actively tried to point this out to various hospitals, but without the active cooperation of the hospital staffs it is a difficult problem. Moderate success has been achieved though, and three hospital staffs have indicated their interest in getting proper departments. Physical medicine, formerly physical therapy, has become an indispensable part of medicine, and any hospital lacking proper facilities is incomplete and its staff is working at a disadvantage.

Our second endeavor has been to formulate an acceptable standard for the education and training of technicians in this field. At present there are no standard requirements in the state. It is possible for a person to take a correspondence course and then claim to be a technician and offer to treat sick people. This contrasts sharply with the requirements advocated by the A.M.A., which suggests either a nurse's education or two years of college preparatory to at least one year's study of physical therapy at an acceptable school. The year's work on this problem has consisted of discussions and collection of information, which may ultimately lead to some concrete proposals.

We believe that the program we have laid out will serve the best interest of the patient and deserves the active support of the profession.

WORKMEN'S COMPENSATION

William K. Harryman, M.D., Chairman, Hackensack

We have accomplished a few things this year. One is the request for the reprinting of an article published some nine years ago concerning Workmen's Compensation suggestions for the general practitioner. This has been re-written and is in the hands of the Department of Labor for their criticism and should be in the State Society offices soon. Also, the matter of increase in fees to be charged for compensation cases has been taken up with various representatives of some of the leading insurance companies.

Otherwise nothing of particular importance has come to us and we have only received one or two bills introduced into the legislature concerning Workmen's Compensation matters which have been called to our attention so far. These have been taken care of as soon as they were received.

SPECIAL COMMITTEES

MILITARY SERVICE

R. L. Sharp, M.D., Chairman, Camden

The Committee on National Emergency Medical Service of the American Medical Association has mailed to more than 45,000 discharged Medical Officers of World War 2 a comprehensive questionnaire.

Dr. Edward L. Bortz of Philadelphia, Chairman of this Committee, stated that the result of the questionnaire would serve as a useful guide in preparing for any new national emergency and urged that all returned medical officers express frankly, fully and completely their reaction to military service.

The results of this will be tabulated and analyzed in detail.

The State Committee has nothing to add for we feel that the questionnaire is complete and comprehensive, but we do urge the cooperation of all those receiving the questionnaire.

The Committee did feel that in certain areas of the state there could have been more careful selection of medical personnel in the past emergency and thought that it might be well in the future to keep a listing of the personnel available for emergency and those who were essential to home care.

In general we felt that the State Procurement and Assignment was well done, but the National Procurement and Assignment was ineffective. Many medical officers received letters from the National Procurement and Assignment urging them to enlist after they had been in service two years or more.

VETERANS LIAISON

Joseph F. Londrigan, M.D., Chairman, Hoboken

To meet the need for doing back-logged claim examinations for the Veterans Administration, this committee proceeded with the organization in individual counties of examination units in hospitals in August 1946. Each county society was urged to organize a plan for veterans medical care patterned after the one already in existence in Monmouth County, and to make a separate contract with the Veterans Administration in accordance with the wishes of that agency for the purpose of forming examination units and certifying reputable medical examiners.

The Veterans Administration desired centralized facilities to permit all examinations of a veteran in the one place. Physicians were to be paid by each County Plan on a fee-basis arrangement, the Plan billing VA for the work accomplished. In addition to fees for each examination, VA would pay an administrative fee of $2.50 when more than one examination was to be done.

To permit flexibility and the operation of as many units as demand would require, the accounting operations were centralized. All cases released by VA would first go to the Liaison Officer who would have them processed through the service bureau of International Business Machines Corporation, one block from the VA Regional Office in Newark. This bureau would make the bill for each Plan for submission to VA and later the checks for the physicians.

Although this committee pursued its task with great energy, action in Washington on the contracts submitted by Monmouth Plan and Hudson Plan was being delayed for almost two months. On October 31, 1946, your chairman, the Liaison Officer, a member of the committee, (Dr. W. G. Herrman) and Mr. John F. Bruther, attorney, met with General Bradley and Dr. Hawley. Washington had redrawn the contracts and made minor changes but they were signed and completed on that day; yet Monmouth and Hudson Plans were not available to the Newark Regional Office until it received photostat copies. Examinations were issued in November, since which time both Plans have been holding weekly sessions.

Contracts submitted by Essex, Middlesex, Warren, Hunterdon, Ocean and Morris in November were not made operative by VA until January, 1947. As of March 1, 1947, only Middlesex was receiving examination requests from VA. Contracts submitted by Passaic and Bergen on December 12, 1946, were made

operative in the week of February 9, 1947, by release of requests. Contracts submitted by Union, Mercer and Gloucester in the middle of January, 1947, are still in abeyance.

The gigantic load of 130,000 cases (said to have been VA's backlog) upon which this program was conceived began to disappear, without physical accomplishment so that by November, 1946, the Liaison Officer found it necessary to warn this committee of his suspicion that the actual load was almost small enough for VA to handle itself in its own facilities in Newark, Paterson, Camden and Union City. A facility in Trenton is now being developed. Essex Plan received an acknowledgment from VA in Newark that the backlog was not sufficient to call for use of the Plan.

The situation has not yet been made clear as to what volume of work the established Plans will be called upon to do, although it is obvious from reports from the Liaison Officer that VA is practically up to date on claim work. Some cases are being released to Passaic, Bergen, Monmouth and Middlesex. Hudson, which was doing a total of about one hundred a week in five units has been reduced to a trickling concern. Whether VA finds it necessary to begin large-scale examining of veterans in the immediate future has not been made known by VA. However, the Plans are ready to do whatever VA requires.

I wish to express my appreciation to the members of this committee who have done an excellent job of organizing and arranging the units suitable to function at short notice, and extend the thanks of this committee to Mr. John Bruther who has handled the legal aspect of the Plans in a magnificent and efficient manner.

Our Liaison Officer, Dr. Yorke has given unstintingly of his time and efforts to make the functioning of these units the success they have been, and will be, should the VA request full scale operation in the future.

APPROVED AGENCIES

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY MEDICAL-SURGICAL PLAN OF NEW JERSEY

Norman M. Scott, M.D., Medical Director, Newark

This report is based upon the experience of the above named organizations during the calendar year of 1946. A supplementary report on Medical-Surgical Plan will be submitted at the time of the Annual Meeting of the Society covering the 1946-47 fiscal year.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

The accounting records of Medical Service Administration are set up under the following headings:

CORPORATE ACCOUNT
REVOLVING ACCOUNT

and a separate checking account pertaining to each plan operated, consisting of income to that plan less its administrative allotment which is deposited in the Corporate Account.

All administrative income is deposited in the Corporate Account. The administrative income during the fiscal year was:

$ 8,150.00	allotted by The Medical Society of New Jersey.
10,000.00	allotted by The Medical Society of New Jersey for organization and initial operation of Veterans Administration Plan.
5,938.50	administrative allotment (8% of income) from Veterans Administration for two-month period in which the Plan operated.
1,299.85	administrative allotment (10% of income) from the City of Newark Plan. Plan.
517.20	administrative allotment (10% of subscription income) from Farm Security Administration Plan.
$25,905.55	

All administrative costs are expended through the Corporate Account or by money transferred from Corporate Account to Revolving Account. This total income to the Corporate Account is expended to cover administrative costs of Medical Service Administration and the plans it operates.

The largest item of administrative costs during the year was the Veterans Administration Plan. This Plan was operated from March 15th to May 13th. The total administrative income of the Plan was $15,938.50. Cost of organizing the Plan and administering its affairs from March 15th to date was $16,224.90, leaving a deficit of $286.40. Included in this expenditure was an item of $1,500 for legal advice, and the expenses of Dr. Yorke as VA coordinator amounted to $1,965.25 covering a three-month period. This latter is reimbursable to us by Veterans Administration at three month intervals. At present there is a balance in the Corporate and Revolving Accounts of $9,477.15 with an outstanding reimbursable item (accounts receivable) due from Veterans Administration of $1,931.31 representing Dr. York's salary and expenses for the last three months.

Medical Service Administration during the past year has operated the Farm Security Medical Plan, The City of Newark Medical Plan and for two months the Veterans Administration Medical Plan.

FARM SECURITY MEDICAL CARE PLAN

We have administered this Plan for five years, for the benefit of the clients of Farm Security Administration, providing services of general practitioners in the form of office calls and home calls at a cost of $16 to $24 per year per family, depending upon the size of the family.

During the past year, as the economic condition of this group improved, there has been a progressive decrease in the number of participating families. The highest number of participating families was 455 in March 1944. The present enrollment is 211 families, about 25% of eligible group. This has resulted in an adverse cross section of health in the group with a high sick rate which cannot be supported by the subscriptions. The sick rate in the remaining group has risen from 57.3 per 1000 in 1945 to 75.7 in March 1946 and in November 1946 had risen to 161 per 1000.

We are reluctant to give up this Plan. It has filled a need of a worthy group. The income to the profession from this group has been better than it otherwise would have been. It has given us an opportunity to experiment with and study the problem of rural medical care among a low wage group. However, since only 25% of eligible families are interested in continuing as subscribers, and since the present income is not sufficient to support our modest fee schedule, the Plan, with the approval of the Board of Trustees of the Society, will be discontinued at the expiration of its outstanding contracts. We are not alone in this experience. Similar Plans in other states are meeting the same difficulties.

VETERANS MEDICAL CARE PLAN

We operated this Plan from March 15th to May 13th.

The total income received to date for services rendered during this two month period is $79,440.65 of which $5,938.50 was allotted for administrative expense and $73,502.15 paid to physicians. This involved the care of 5,290 veterans by 1,455 physicians. There are three small outstanding vouchers in the hands of Veterans Administration totalling $252.95.

On June 18th our original contract was superseded by a new contract providing for the Regional Office of Veterans Administration assuming the administrative details of the Plan and for the employment of a physician coordinator by Medical Service Administration for duty in the medical section of the Regional Office, his salary and expenses to be paid by Medical Service Administration which will be reimbursed by Veterans Administration at three month intervals.

THE CITY OF NEWARK MEDICAL PLAN

This provides payment for medical care rendered the indigent and medically indigent when confined to their homes by illness. The term "indigent" refers to the persons whose names appear on the welfare rolls of the City. The number of indigent in January 1946 was 2100 persons. The number in December was 2103 persons. The number was higher during the summer months, making the mean number for the year 2155.

The number of persons receiving medical care during the year was 830, or 38.5% of the indigent population.

The fees during the year (April 1946) were increased from $2.00 per day call to $3.00, and from $3.00 per night call to $5.00.

The cost per person on the welfare rolls for the year was $2.21 or $0.184 per month. This cost of 18 cents per person per month at the new fee schedule compares to a cost of 12.5 cents per month in 1945 at the old fee schedule.

The highest sick rate occurred in May, not during the winter months.

The term "medically indigent" refers to a group of otherwise self-supporting persons who are defined as medically indigent by the City Board of Health when they apply for medical care. It is impossible to determine the total number of medically indigent in the City

as they are not defined until they apply for medical care. The medically indigent load, as judged by the cost of their medical care, is currently about three times the size of the indigent load. The size of the load has more than doubled during the past year. This reflects the economic changes in industry and the changes in the labor situation which have occurred during the past year. In the past years 2950 families were so classified, and the cost of their medical care was $9,365.50. Their highest sick rate was in April.

This Plan is an innovation. It is not an insurance plan. There is no formal contract between Medical Service Administration and the City of Newark. Its innovation arises from the fact that it operates on a reimbursement basis in accordance with the provisions of a "Memorandum of Understanding" agreed upon by Medical Service Administration, the City Department of Health and the City Department of Welfare. This "Memorandum of Understanding" outlines the objectives of the Plan, its administrative procedures, states the fees to be paid and is sufficiently elastic to allow adaptation of the Plan to meet the needs of the individual patient and unforeseen contingencies. The standards of medical care, and matters pertaining to patient-physician relationship, are governed by Medical Service Administration with the advice of an advisory committee of Essex County Medical Society. Physicians submit their bills directly to Medical Service Administration and are paid directly by Medical Service Administration. Claims as approved by Medical Service Administration are forwarded to the City and Medical Service Administration is reimbursed at monthly intervals, the cost of claims plus 10% to assist in defraying administrative costs. The cost of the care rendered the indigent is borne by the City of Newark with the assistance of state funds through New Jersey Municipal Aid Administration. The cost of care rendered the medically indigent is borne entirely by the City.

It is the only Plan we know of which operates on a reimbursement basis, allowing free choice of physician and payment for physicians' services on a fee for service basis. It has reduced the cost to the City for care of its indigent. It has given satisfaction to the patients. It is adaptable to any municipality and a successful experiment in what may be accomplished through the cooperation of government and organized medicine in any situation where medical care is subsidized by tax funds. We recommend a continuation of the Plan.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

There were 88,088 persons enrolled under effective contracts as of December 31, 1946. There was an increase in enrollment of 80% during the year. The growth of the Plan has not been as rapid as experienced by some other Plans. This has undoubtedly been an advantage to us in that it gave an opportunity for seasoning our groups rather than overloading our total enrollment with a large number of new groups in which the initial cost is high.

Four hundred and fourteen groups are now enrolled, an increase of 149 groups during the year.

Our new groups are averaging 50 per cent enrollment. The percentage of enrollment in old groups is constantly improving. We find it of definite advantage to have the employer contribute to the subscription cost of his employees. Of the groups now enrolled the employer pays a part or the entire cost in 235.

The earned subscription income for the year was $504,227. As of December the annual income was at the rate of $718,668. The number of persons per contract (2.2) and the income per person (67-68 cents) remain quite constant.

SICK RATES

The sick rate, or as otherwise termed, the incidence of utilization of our contract was at the rate of 86 per 1000 per year. This as compared to 81 in 1945, and a normal hospital admission rate for the state of 77 per 1000. The increased rate, over last year, may be accounted for by the expansion in our scope of eligible services during the past year to include payment in accordance with our schedule of benefits for operative surgery performed in out-patient departments without formal admission to hospital, tonsillectomies performed in physicians' offices, and emergency surgical services (up to $25.00) occasioned by accidental injury rendered anywhere within 24 hours of the accident. The total number of cases paid for was 5,829 of which many involved more than one bill. This, as compared to 3426 cases in 1945. The average amount paid per case was $63.57 as compared to $60.50 in 1945. Sixty-five per cent were surgical, twenty per cent medical, twelve per cent obstetrical and three per cent medical and surgical. Adult females, mostly wives, continue to be our greatest liability, constituting 55% of all cases during the year.

Sixty-nine per cent of income was expended for claims as compared to 64 per cent last year.

Sixteen and eight tenths per cent of income was expended for operating costs, of which twelve per cent was paid to Hospital Service Plan and 4.8 represented the costs of our office. This as compared to 17.5% last year.

PUBLIC RELATIONS

All voluntary medical service plans need a high type, ethical, public relations program. The type of public relations we should carry on in our own name is represented in the pamphlet of information recently distributed to all physicians in New Jersey. We need more public relations emphasis on the philosophy of the voluntary movement, the intent of the medical profession and the obligation of individual physicians to the voluntary plan movement. This we believe can best be conducted by the Society.

All in all, Medical-Surgical Plan is a success. It does provide for the greatest need of under average income persons. It is self-supporting and has accumulated satisfactory reserves. It has never been in financial difficulties. The cooperation of the individual physicians has been excellent. The number of complaints received in our office is surprisingly small.

The national picture and the support of the American Medical Association is excellent, but a discussion of the national program is not considered as within the scope of this report.

A supplementary report on Medical-Surgical Plan will be submitted at the time of the Annual Meeting.

STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

E. S. HALLINGER, M.D., Secretary, Camden

During the period of January to December, 1946, the Board examined one hundred and twenty-one applicants for a license to practice medicine and surgery. Ten of the applicants were graduates of osteopathic colleges; nine of these passed the examination.

The Board also examined fourteen applicants for a license to practice chiropody.

Results of the examination are displayed in Table I.

Four hundred and twenty-five licenses were issued to applicants for endorsement of a license from another state, or a diploma from the National Board of Medical Examiners, who presented credentials meeting the requirements for examination in force in New Jersey at the time they were examined. This group of 425 licenses by endorsement is shown in Table II.

All credentials covering medical and hospital work submitted to the Board were verified by questionnaires sent to the colleges and hospitals in this country before a license was issued.

The laws governing the practice of medicine and surgery, osteopathy and chiropractic, do not provide for an annual registration. The Board does not, therefore, know whether the number of licentiates in the state now in practice is increasing or decreasing.

Annual registration would give the Board accurate information relative to the number of physicians practicing in New Jersey and would enable the licensed physicians to assist the Board in enforcing the law by reporting unlicensed physicians in their vicinity.

The laws governing the practice of chiropody and midwifery provide for an annual registration and our records show an increase of seventy-two in the number of chiropodists registered on November 1st, 1946, and an increase of two midwives for the same period.

ENFORCEMENT

Following is a brief report of the Board's activities in enforcing the laws which it administers:

COURT CASES—VIOLATION OF MEDICAL, ETC., LAWS

Convicted, Pleaded Guilty or Settled	34
Pending in the Courts	14
Decision Reserved	2

CASES—SUPREME COURT

Lost by Board, Writ of certiorari allowed by Supreme Court—Lower Court reversed	1
Won by Board—committed to jail—released immediately by sheriff—Action attacked by Board—Writ of certiorari allowed—pending	1

Hearings Before Board	
Medical—License suspended	3
Medical—Petition for reinstatement denied	1
Medical—Revocation or suspension pending	2
Medical—Complaint dismissed	1
Medical School—Revocation of license pending	1
Chiropody—Revocation or suspension pending	1
Physio-therapists	12
Laying-on-of-hands	1
Medical — revocation	2
Chiropody — revocation	1
Medical school — revocation	1
Optometrists practicing medicine	1
Electro-therapists	1
Massage	11
Unlicensed medical school	1
Miscellaneous	4

In all there were 32 cases presented to the courts and nine hearings before the Board.

Representatives of the Board made 220 investigations, as indicated in Tables III and IV.

A more detailed analysis of the last 26 cases investigated is presented below.

TABLE 1
CANDIDATES FOR THE 1946 EXAMINATIONS

	Total	Passed	Proportion Passed
MEDICAL			
United States			
Graduates of Medical Schools	95	94	99%
Graduates of Osteopathic Schools	10	9	90%
Canada	2	2	100%
Italy	5	4	80%
Great Britain	3	3	100%
Germany	3	1	33%
Hungary	1	1	100%
France	1	1	100%
Lebanon	1	1	100%
Chiropody			
United States	14	14	100%
	135	130	

Note: All candidates were full citizens of the United States.

TABLE II
LICENTIATES BY ENDORSEMENT

Countries	Total
United States	361
Canada	11
Great Britain	13
Austria	12
Germany	6
Italy	2
Hungary	3
France	4
Switzerland	10
Russia	1
Lebanon	1
Czechoslovakia	1

TABLE III
CLASSIFICATION OF INVESTIGATION AND INSPECTIONS

Type of Cases Investigated	No. Investigated
Pharmacists practicing medicine	19
Prescribing herbs and drugs	27
Unlicensed medical doctors	38
Unlicensed chiropractors	65
Licensed chiropractors exceeding license	4
Licensed chiropractor assisting an unlicensed person	1
Licensed osteopath exceeding license	1
Licensed osteopath failing to display name	1
Licensed osteopath assisting an unlicensed person	1
Unlicensed chiropodists	3
Licensed chiropodists failing to display certificates	10
Licensed chiropodists practicing under another name	2
Licensed chiropodists practicing chiropody after failure to register	2
Licensed midwife practicing midwifery after failure to register	1
Naturopaths	10

TABLE IV
ANALYSIS OF INSPECTIONS AND INVESTIGATIONS

Total number of investigations and inspections made	220
Total number of visits made and treatments received in making the investigations and inspections	860
Average number of visits per investigation	3.9

SPECIALISTS IN VA PROGRAM

If you are participating in the VA personal-physician treatment program, and wish to be listed as a specialist, entitled to specialist's fees, submit the following information to Dr. Edward T. Yorke, room 316, Veterans Administration, 20 Washington Place, Newark 2, N. J.:

(a) How long you have been practicing the specialty, and what speciality? (b) Board certification if any; (c) Fellowship in A.C.S.,A.C.P. or comparable national specialty organization; (d) Hospital staff appointments with rank and title; (e) Other qualifications including graduate courses, residencies, etc.

COUNTY SOCIETIES

ATLANTIC

Lawrence A. Wilson, M.D., President, Absecon

Atlantic County's program, on the whole, has been satisfactory. There has been much favorable comment. We have had such speakers as, Doctors Theodore Fetter, Louis Clerf, George Wilhauer, Baldwin L. Keyes, John H. Gibbon, Jr., from the faculty of Jefferson Medical College; Doctors W. Wayne Babcock, and Hugo Roesler, from the faculty of Temple Medical College; Dr. John Allen Bertolet, coroner of Phildelphia; Dr. Edward L. Bortz, vice-president of the American Medical Association, and Dr. George F. Lull, of Chicago, General Manager of the American Medical Association. These men have given us excellent papers and we should profit by their experiences.

The committees have functioned most satisfactorily. The Board of Censors has acted on twelve applicants and all were elected to membership. Dr. David B. Allman, as chairman of the committee for Crippled Children, has worked consistently in cooperation with Dr. William L. Rumsey, the Medical Director of the Cardiac Program of the State Crippled Children Commission, and there has been established, at the Betty Bacharach Home, a Cardiac Clinic. They have outlined a comprehensive program. The Broadcasting Committee under the leadership of Dr. Sloan G. Stewart, instituted and carried out a series of broadcasts over WBAB, featuring talks from the returned medical veterans, citing advances in medicine as learned in the services. The Graduate Medical Education Committee, also under the Chairmanship of Dr. Sloan G. Stewart, has established a course of lectures by such men as Dr. Harrison Flippin, Philadelphia General Hospital; Dr. Maurice Breuger, New York Post-Graduate Hospital; Dr. John Q. Griffith, University of Pennsylvania; Dr. Thomas Fitz-Hugh, University of Pennsylvania; Dr. Joseph Hughes, Women's Medical College of Philadelphia; Drs. Henry T. Wycis and John Royal Moore, Temple University Medical School; Dr. Francis Wood, University of Pennsylvania; and Dr. Francis Lukens, University of Pennsylvania. Seventy-eight men enrolled in this course. This denotes the enthusiasm with which this course is being received.

The Tuberculosis Committee, Dr. Charles Hyman, Chairman, is trying to educate the public to be more conscious of the necessity of an early diagnosis in tuberculosis, and early hospitalization of these cases, with a hope that the mortality will be reduced.

Chairman S. Eugene Dalton, of the Committee on Conservation of Hearing, reports his committee has agreed to accept, in principle, the outline in a brochure, presented to the American Academy of Ophthalmology and Otolaryngology in Chicago last January. This brochure portrays the work done in South Jersey in the last few years. The Committee also agreed to support the Otologic Research Foundation to be established in New Jersey in the future. Superintendent Floyd B. Potter, of the Atlantic City School, met with the committee and helped prepare plans for screening out those with defective hearing among the school children.

Dr. Ward Scanlan, Chairman of the War Chest Committee, reported receiving excellent cooperation and excellent donations from all of the physicians.

Probably the most significant achievement of all was, when the Postwar Committee, under guidance of Dr. V. E. Johnson, undertook to advise the Society in the matter of liaison with Veterans Administration. The outcome of the venture was the formation of a separate, incorporated organization, in cooperation with the Veterans Administration, to examine veterans and determine their eligibility to receive pension.

It is with regret, that I have to report the deaths of Dr. Samuel Barbash and Dr. Clyde M. Fish, and their passing will be deeply felt. They were respected not only in the field of medicine, but in the civic communities as well.

This Society will again play host, not only to the State Society, but to the Centennial Meeting of the American Medical Association. Dr. David B. Allman and Dr. Hilton S. Read, are co-chairmen of the Committee on Arrangements, and report that the arrangements are almost complete. We expect that this will be the largest meeting ever, and wish to make it a success.

As for me, the year has been a pleasant one and the cooperation of all members has made it so.

BURLINGTON

William E. Bray, M.D., President, Pemberton

The Burlington County Medical Society has enjoyed a most successful and educational year. Considerable attention was given and much time devoted to the organization of a clinic for the examination of veterans. Under the direction of Dr. S. J. Lloyd, of Trenton, the Society's Veterans Liaison Committee arranged to examine veterans at the Zurbrugg Hospital in Riverside. The plan, however, was given up when it was discovered that too few veterans were to be examined to make the plan feasible.

The program committee endeavored to satisfy the wants of the general practitioner in their types of program. Dr. J. F. Pessell, of Trenton, gave a helpful paper on rectal bleeding. Office gynecology was discussed by Dr. Newlin F. Paxson of Hahnemann Medical College. At another meeting Dr. Edwin Murray, of the Cooper Hospital in Camden engaged us with a discussion of the diagnosis and treatment of coronary disease. These three men presented helpful suggestions which the members of the Society can use in their everyday practices. Dr. J. Quintin Griffith of the University of Pennsylvania brought us some of the most recent treatments of hypertension. Dr. Griffith's stimulating paper was most encouraging in this particular field of medicine which has been such a perplexity to the average practitioner. In February, Dr. Marcus Newcomb, Superintendent of Fairview Sanitorium and Director of the Burlington County Tuberculosis League, gave a report and analysis of a survey of Tuberculosis in Burlington County. Dr. Newcomb's analysis supported very emphatically that mass x-raying for Tuberculosis was of great value.

The Postgraduate Committee of our Society is arranging a course of medical study to be presented over a six-weeks period starting in April. Seventy-five per cent of the members have expressed their interest in such a course and it is hoped that with the success of this venture similar instruction may be given each year by the medical society.

During the year, the Cancer Committee has been active in cooperation with the Burlington County Chapter of the American Cancer Society. A Cancer Clinic is being established at the Burlington County Hospital.

Calls for speakers at gatherings of various service clubs have been answered and the usual topic presented has been along the lines of socialized medicine.

Since social functions of the Society have been entirely neglected during the war years, we are now planning, in conjunction with the Woman's Auxiliary, to present a social event for the doctors and ladies at a final meeting in May. This is to be held at the Riverton Country Club and portends a happy conclusion to a successful year.

With a number of new men returning from the service the Society membership has increased twelve-fold.

As president of the Society in this the first postwar year, it has been a pleasure to guide and direct the many activities. I feel that the general program of the Society has been a well rounded one and the interest taken has been constantly increasing. Meetings are better attended and the spirit of the entire Society has been that of cooperation.

CAPE MAY

J. S. D. Eisenhower, Jr., M.D., President, Wildwood

The past year in the life of the Cape May County Medical Society has been characterized by three activities: One—the return to the Society of the veterans; Two—entry into the Society by veterans establishing practices in our county; Three—the planning and campaign for the construction of the Burdette Tomlin Memorial Hospital.

The first two points hardly require elaboration since every Society should be experiencing these pleasurable reunions and re-establishments of professional and social friendships.

We, as physicians in Cape May County have linked our hands with the unselfish laymen of our County who are determined that we shall have our "workshop", and that the residents of our county will be afforded the needed medical aids furnishable only by a hospital—which we now so sorely lack. The financial campaign has been successful. Organization plans for staffing are held in abeyance only so that construction may be started first—which we

all hope and plan on as soon as materials become reasonably available.

The Cancer Committee of the Society is coordinated with the local Cancer Committee and has new stimulus—again supplied by the expectancy of a physicians' "workshop".

As meeting places were scarce, and attendance unpredictable due to added professional calls during the war, the Society's meetings heretofore have not been characterized by visiting speakers. Henceforth it is expected and planned that our meetings will be augmented by speakers from a medical center who will speak to us as general practitioners—for such, in very great majority, we are.

The members, individually and collectively, of the Cape May County Medical Society deserve credit for their giving of themselves under difficulty for a long time. In the coming year it is hoped and expected that the interest accrual of this medical assiduity will begin to be received by these men through the beginning realization of our long desired and needed hospital goal.

CUMBERLAND

Albert B. Kump, M.D., President, Bridgeton

The past year has been filled with a joy of many successes, the happiness associated with a return of our physicians from the armed forces and the sorrow of the death of three of our members.

An executive meeting was held at the home of the president prior to each of the regular meetings. The attendance throughout the year, at the meetings of the Executive Committee, was approximately 95 per cent.

We enjoyed the novelty of being entertained by the Owen-Illinois Glass Company in Bridgeton, in June and were delighted with the invitation of the company to return each June as their guests. We were honored by an invitation and were entertained by the Kimball Glass Company in Vineland. In both instances we were given an insight as to the industrial duties of many of our patients.

During the past year a committee entitled the Veterans Liaison Committee was established. The chairman, Dr. Charles Cunningham, has done nobly as illustrated by the committee's extreme activity.

Resolutions were spread upon the minutes relative to the deaths of Dr. J. Franklin Reeves, Bridgeton, Dr. Helen E. Weithaase, Vineland, and Dr. Kenneth R. Bauman of Millville. The society suffers deeply the loss of these three members.

In addition to the regular committees, a committee of Industrial Medicine was appointed with Dr. James S. Knowles as chairman, Dr. E. J. Thalheimer and Dr. George N. Thomas as members.

There have been taken into the society, Dr. Maurice N. Harris, Bridgeton, and Dr. Louis E. Rosiello, Vineland.

The scientific programs under the auspices of our vice-president, Sidney L. Siegel, M.D., as chairman of the Program Committee, were as follows: William G. Leaman, Jr., M.D., who spoke on "Cardiac Disease"; Michael Scott, M.D., who spoke on "Diagnosis and Treatment of Low Back and Sciatic Pain"; Ralph C. Hand, M.D., who spoke on "Hip Injuries".

The relationship with The Medical Society of New Jersey has been maintained through the Welfare Committee by Dr. Charles Cunningham of Vineland and Dr. Albert B. Kump of Bridgeton.

ESSEX

Thomas W. Harvey, M.D., President, Orange

During the year starting May 1946, the Essex County Medical Society has carried on a busy program both in its meetings and committees. The following list of meetings have been very well attended and have all been most interesting and instructive:—October 1946—U. S. Senator H. Alexander Smith, "American Foreign Policy and Taft-Smith-Ball Health Bill"; November 1946—R. Franklin Carter, M.D., and John Russell Twiss, M.D., "Recent Developments in the Medical and Surgical Management of Biliary Tract Disease";

December 1946—Frank Lahey, M.D., "Diseases of the Colon, Rectum and Ileum"; January 1947—Frank L. Meleney, M.D., "Chemotherapy and Antibiotic Therapy in the Treatment of Surgical Infections"; February 1947—Louis F. Bishop, Jr., M. D., "Management of the Cardiac Patient"; March 1947—S. W. Harrington, M.D., "Carcinoma of the Breast"; April 1947—William Bryant Rawls, M. D., "Medicine in the America of Today and Tomorrow".

The Central Blood and Plasma Bank Committee, under the leadership of Dr. Crecca, plans (as soon as the necessary equipment is obtained) to establish a blood bank in the Newark City Hospital with the assistance of the Red Cross chapters of the county and the generous financial backing of the Board of Freeholders.

We are proud of the successful Post-Graduate Courses given this year under the chairmanship of Dr. G. I. Cetrulo and sponsored by Seton Hall College. They have all been over subscribed and have been greatly appreciated. Twenty-three courses have been given by well known authorities from New York City in the following subjects:

Pathology of internal medicine
Chest diseases
Diseases of liver, gallbladder and pancreas
Gastro-enterology
Surgical pathology
Surgical physiology
Surgical anatomy
Blood dyscrasias
Cardiology
Electro-cardiography
Psychosomatic medicine
Diabetes mellitus and hypertension
Biochemistry
Hematology
Roentgenology
Gynecology
Neuro-psychiatry
Anesthesia
Pediatrics

After much work and negotiation, Dr. J. W. Hurff, chairman of the Veterans Administration Liaison Committee, reported to the Society that the regional VA office in Newark was able to take care of all the examinations of veterans applying for pensions and hence recommended that the elaborate plans the committee made for the examinations be abandoned. The Society regretfully agreed to this, and remains prepared to cooperate if needed.

The Veterans Rehabilitation Committee was very active under the chairmanship of Dr. E. LeRoy Wood. They were in touch with all returning physicians and helped many re-establish themselves in offices and hospital connections.

The Cancer Committee, with Dr. J. I. Echikson as chairman, cooperated with the American Cancer Society and is in the process of establishing Cancer Clinics at the various hospitals in the county.

Last summer the Society suffered the loss of its most distinguished member, Dr. Wells P. Eagleton. Dr. Eagleton was an aural and brain surgeon of world-wide reputation. He ably represented New Jersey as its delegate to the A.M.A. and was always a champion of the highest ideals of medicine.

During this year the president has received splendid support and cooperation from the members of the Council and of the entire Society and hereby extends them his thanks.

GLOUCESTER

Louis K. Collins, M.D., President, Glassboro

This year has seen practically all of our medical veterans back in their former offices, and added interest has been shown in the activities of the County Society. Our attendance record on the whole has surpassed the prewar level.

As an innovation, the September meeting was held at the Owens-Illinois Glass Closure Plant in Glassboro. Members of the Woman's Auxiliary were present and enjoyed an inspection tour of the factory prior to the respective business meetings. Later, the ladies again joined the men to witness the film "The Doctor in Industry", following which all enjoyed refreshments supplied by the Owens. In October, the *Annual Social Session* was addressed by Dr. J. Lynn Mahaffey, Director of the State Department of Health. At this time, the society presented suitable tokens of esteem to two of Gloucester county's outstanding medical personalities, Mrs. Frederick G. Wandall, current president of the State Auxiliary, and Dr. Ralph K. Hollinshed, recent past-president of the State Medical Society.

At our regular meetings we were privileged to hear the following leading clinicians discuss timely and extremely valuable medical subjects: Dr. John B. Montgomery, Dr. George B. Geckeler, Dr. Louis H. Clerf, Dr. Herbert R. Hawthorne, Dr. Gabriel Tucker, Dr. John E. Eads, Dr. John Royal Moore. The February meeting was complicated by a driving blizzard, but 50 per cent of the members made it for the double-header program presented by Drs. Tucker and Hawthorne.

The Cancer Control Clinic sponsored by the society has been in operation for several months at the Underwood Hospital. We recently agreed to sponsor the Red Cross Blood Donor Service, since a blood bank is not feasible in Gloucester County. Our Corporation for the examination of veterans has been set up, although so far no examinations have been made. A Post-Graduate course in conjunction with Camden County is planned for the spring months. All of the committees have given excellent support to the president and have helped make the 1946-47 sessions instructive as well as pleasant.

HUDSON

CLAUDIO E. MCNENNEY, M.D., President, Jersey City

Of our approximately one hundred sixty members who served in the armed forces, all have returned to civilian life and the practice of medicine except six—Drs. Davis, Miller, Santosky, Smith, Spohn and Wolbert. With the return of most of our members, the spirit of restiveness and the feeling of suspended action that prevailed during their absence have given place to an atmosphere of confidence and constructive planning.

Five of our scheduled eight monthly meetings, all fairly well attended, have taken place. Men outstanding in their respective fields have contributed to our scientific sessions, among them Dr. Robert B. McGraw, Dr. James S. Greene, Dr. Frank L. Meleney, Dr. Ashley W. Oughterson and Dr. Virginia Kneeland Frantz. This season, the serving of a collation after the regular monthly meeting has added much to our enjoyment, the absorption of nutritive elements helping us to assimilate the scientific data.

By the end of the season, we anticipate that our list of new members will be quite imposing. As of this date, we have added thirty-one new names to our roster, have reinstated five former members, and have welcomed to our ranks three physicians from constituent societies, our total membership at this time having reached the six hundred mark. One honorary membership has been conferred, Dr. Wallace Pyle of Jersey City being the recipient. We report with regret the passing of nine members, among them Dr. Reeve L. Ballinger, who for many years was one of the most active men in both the county and the state medical societies.

The various committees have exerted their usual influence, the Cancer Committee (of which Dr. Faison is chairman) being among the most active—called upon, as it has been, to guide and direct the efforts of the local chapter of The American Cancer Society as they applied to matters medical.

Undoubtedly the most outstanding project of the Society, and one for which we are indebted to Dr. Joseph F. Londrigan who worked long and arduously for its success, is the Hudson Plan as described in the existing contract between this Society and the Veterans Administration, under which five units have been established in Hudson County for the examination of veterans for pension rating purposes. At the present time, units are operating at Medical Center in Jersey City, St. Mary's Hospital in Hoboken, North Hudson Hospital in Weehawken, Bayonne Hospital in Bayonne, and St. Francis Hospital in Jersey City. Men practicing general medicine, as well as specialists in the various fields, are participating in the program. We are deeply grateful for the wholehearted cooperation of our members, without which, the plan could not have been carried out. It is hoped that within a short time, operations at the various units will have expanded sufficiently to have utilized the services of every physician who signified his willingness to cooperate in this gigantic task.

We should like to include in this report a few of the remaining items on our agenda:

Our Committee for Post-Graduate Medical Education under the chairmanship of Dr. George Ginsberg is about to announce a post-graduate course in medicine to be conducted by this Society in conjunction with Rutgers University. A series of lectures to be given by noted medical authorities will begin on April

18 and continue for a period of six consecutive weeks.

As one of the social activities of the later season, we are happy to mention our first annual dinner since pre-war days. Plans are proceeding apace, and we look forward with eagerness to having as invited guests, the members of this Society who were in military service. Our arrangements include a prominent speaker, an excellent dinner and all that goes with it, and a festive evening of hearty goodfellowship, one worthy to be remembered by ourselves and our guests.

We look forward with pleasure to greeting old friends and making new ones under the hospitable roof of Haddon Hall on the occasion of the 181st Annual Meeting of The Medical Society of New Jersey.

HUNTERDON

Philip W. Baker, M.D., President, High Bridge

Although enthusiasm in the activities of the county society reached its lowest ebb during the war years, we have been fortunate to experience a revival of hope and interest in the society's activities through the return of former members from the armed forces and the augmentation of our ranks by new members from the younger group.

This interest was mainly accomplished by having varied meeting programs that would appeal to all of the physicians.

Highlight of the year was the celebration of the 125th anniversary of the Society, at which time we had an excellent turn-out to hear such eminent members of our state organization as vice-presidents Hornberger and Norton.

We also succeeded in consummating a Veterans Administration plan with Warren County Society officials who were extremely helpful and cooperative in setting up a satisfactory and desirable program.

On the whole, this was a year of revival of spirit and society interest pointing for a brighter and more promising future.

MERCER

J. L. Wikoff, M.D., President, Trenton

During 1946-1947 the majority of physician-veterans resumed practice in the county and many new names were added to our membership. The return of these men and the admission of new members accounted for an improved attendance at our monthly meetings.

A tragic blow was suffered by the Society in the loss of Dr. Harry North, our treasurer. It is with regret that we report the deaths of Dr. Levin and Dr. West.

Seven of our eight scheduled meetings have taken place. Scientific programs included: "The Diagnosis of Cancer of the Stomach", Dr. William A. Cooper; "The Management of Prolonged Labor", Dr. Samuel A. Cosgrove; "Anesthesia—Past,Present and Future", Dr. Henry S. Ruth; "The New York Plan for Hospital and Medical Care", Dr. Dean A. Clark. An innovation was instituted this year in the form of clinical meetings presented by Staffs of the local hospitals. The Staffs selected this year were those of the Mercer Hospital and the New Jersey State Hospital.

The Veterans Liaison Committee initiated the Mercer County Plan for Veterans Medical Service in accordance with the recommendations of the State Society. Several special meetings of the Society and exceptional demands upon the members of the committee were necessary for the consummation of this project. It now awaits approval of the Veterans Administration.

Plans are being formulated for Public Health Week to be held under sponsorship of the State Society in the Fall.

Renewed activity of the Cancer Committee with the aid of the representative of the State Committee has resulted in the resumption of the cancer control clinics in our hospitals. These clinics are now carrying an appreciable load and the results of their work is gratifying.

The Rheumatic Fever Committee is making plans for the establishment of a clinic to care for those afflicted with rheumatic heart disease. Hospital facilities will be available and the personnel will be made up from our mem-

bers. This clinic should be functioning within the next year.

The Infant Mortality Committee continues to be active and through its recommendations much good has been accomplished.

The Maternal Welfare Committee functioned as a separate group in addition to its duties on the Infant Mortality Committee and promises to be of great value. At an open meeting an analysis and discussion of the maternal deaths for 1946 proved interesting and helpful. The committee holds other open meetings as required and acts in an advisory and consultative capacity for those physicians who wish to present obstetrical problems.

The Committee on Post-graduate Training has arranged for a series of twelve two-hour lectures to be given in May.

Cooperation of committees and members of the Society rendered the most difficult problems mere routine. Naturally such an attitude was gratifying to the officers of the Society.

MIDDLESEX

FREDERICK S. TABER, M.D., President, New Brunswick

The activities of the Middlesex County Medical Society are best reflected by a recital of the programs of its meetings. Here is the account to date:

January—Dr. Bacon F. Chow, Ph.G., Squibb Institute for Research, New Brunswick, New Jersey: "Plasma Protein Regeneration following Administration of Protein Hydrolysates."

Special meeting to discuss plans for Veterans Care.

February—Dr. Martin G. Vorhaus, Attending Physician, Hospital for Joint Diseases, New York City, "Present Evaluation of Thiouracil in the Treatment of Hyperthyroidism."

March—Dr. William Goldring, Assistant Professor of Medicine, N.Y.U., Medical College, "Medical and Surgical Treatment of Hypertension."

April—Dr. J. W. Bird, Past President, Medical and Chirurgical Faculty of Maryland, "Medical Care Program of the State of Maryland."

May—Dr. Frank R. Smith, New York, N. Y., Associate Attending Surgeon, Memorial Hospital, "Diagnosis and Treatment of Carcinoma of the Uterus".

June—Social meeting of physicians and dentists at Jumping Brook Country Club, Neptune.

September—Special meeting of Veterans Liaison Committee, for the purpose of discussing plans for incorporating the Medical Society to care for veterans applying for pensions.

Special meeting of Executive Council and Veterans Liaison to further plans to incorporate Middlesex County Medical Society to care for veterans applying for pensions and to establish headquarters for the examinations of veterans.

October—Dr. S. E. Moolten, Pathologist and Director of Laboratories, St. Peter's and Middlesex General Hospitals, New Brunswick, "Mosquito-Borne Encephalitis — a Problem for the Physician".

November—Joint meeting of physicians and pharmacists of Middlesex County; Mr. Daniel A. Belmont, New York District Narcotic Division, "Narcotics Prescription Writing".

December—Annual Dinner Meeting, election and installation of officers. Carlyle, the magician, guest entertainer.

MONMOUTH

JAMES P. PREGNALL, M.D., President, Asbury Park

The Monmouth County Medical Society has been particularly active during the past twelve months, and it is with gratification that we can report that all objectives of the Society have been wholly completed.

It is with regret that I have to report the loss of three former members as a direct result of their service in the Armed Forces of our Country. Dr. Howard B. Mason, Freehold; Dr. Edmund Kanses, Rumson, and Dr. Murray Woronoff, Keyport, will all be very much missed by our Society, not only because of their professional ability, but also because of their attributes as friends. All other mem-

bers of our Society who served in the Armed Forces, have returned with the exception of Lt. Commander William Heatley, who has elected to remain in the service of our government. In addition to our returning veterans we have elected twenty-six new members to our Society, all of whom are beginning their practice in Monmouth County. This is the largest number of new doctors elected to membership in any single year since the organization was founded.

Anticipating the need of first-class medical service for Veterans early in 1945, plans were laid so that Monmouth County Medical Society would be prepared to cooperate fully with the Veterans Administration in rendering such service at the completion of the war. This year our plans were completed, and it is our belief that we have a set-up, which, while not wholly ideal, is without comparison with the rest of the Counties in this Country. Briefly our method of operation is as follows:

1. Every member of the Monmouth County Medical Society has been made a designate physician for the Veterans Administration upon recommendation of the Executive Committee of our Society. The care of the Veterans of this County, therefore, falls in the hands of each and every capable physician in Monmouth County rather than one or two men selected by the Veterans Administration. The Veterans have free choice of physician, and the physicians treat Veterans as any other private patient they attend.

2. By the incorporation of a non-profit organization known as The Monmouth Plan for Veterans Care the Society has contracted to furnish capable specialists, personnel, and facilities for completing pension examinations of Veterans in groups of twenty at weekly intervals. This plan eliminates a great deal of clerical work on the part of the Veterans Administration, speeds up pension examinations, and eliminates the necessity of the Veterans making several visits to specialists' offices for their various specialists examinations. All laboratory work, including x-ray examinations, are now completed the week prior to the pension examination in order that all available information may be on hand for a final and complete diagnosis. The consultation clinics are supervised by a "Chief" who coordinates the activities of the examining physician but does not himself examine. All clerical work, including the making of appointments for Veterans and often times bringing Veterans to the clinic is ably handled by the Monmouth County Organization for Social Service, a highly organized non-profit welfare agency without whose help The Plan could not function. All monies for these pension examinations are paid directly to The Plan by the Veterans Administration and The Plan disburses these monies to the Physicians, Monmouth County Organization for Social Service, and Hospitals.

The Cancer Control Committe of our Society is cooperating wholeheartedly with the state and federal Cancer Committees. They have set up a diagnostic cancer clinic, staffed by capable specialists in all branches of medicine and are functioning smoothly. Equipment for the thorough treatment of all types of cancer has been ordered for each of two hospitals in the County, and the funds for the purchase of this equipment are on hand, however, the equipment has not yet been received. The Cancer Control Clinic in this County is available only to indigent patients as it is felt that those patients who are able to pay can be furnished with the same facilities for diagnosis and treatment by private physicians as can be furnished the indigent patients through the Cancer Control Clinic, thus all funds available for Cancer Control can be used on the unfortunate who are financially unable to pay for proper diagnostic procedures and treatment.

The American Medical Association is studying the problem of furnishing adequate medical care to various farm groups, and recently Mr. Thomas Hendricks, the Executive Secretary of the Council on Medical Services of the American Medical Association, sent a member of his staff, Mrs. Virginia Shuler, to Monmouth County to survey the administration of medical services to the rural areas of this County by the Monmouth County Medical Society and the other public health agencies, particularly the Monmouth County Organization for Social Service. Mrs. Shuler was particularly impressed with the cooperation existing between the Monmouth County Medical Society and all the health and welfare agencies, in providing all needed public health services and other medical care to the patients residing in rural communities.

Until this year the Monmouth County Medical Society has depended upon one of its own members to care for all of the duties of a secretary to its Society, but the secretary has become so overburdened with work that it has become imperative that we have suitable clerical help. With this in mind the dues have been increased to provide funds for a full time clerk in order to relieve our secretary of the endless chores which he otherwise has to perform.

MORRIS

Alden P. King, M.D., President, Dover

The Morris County Medical Society conducted business meetings in October and November of 1946, and scientific meetings in January and February of 1947 with scientific programs scheduled for March and April of 1947, and the Annual Meeting in June.

Most of our business has been devoted to establishing a plan for the examination of veterans in cooperation with the Veterans Administration. We have been advised that our agreement covering the furnishing of physical examinations of veterans for pension rating purposes has been accepted for the period terminating June 30, 1947.

Other business matters have been the Mobile Eye Clinic supervised by the New Jersey Commission for the Blind and the subject of cancer control.

The County Welfare Committee working with the Welfare Board has adopted fees covering patients under control of the Welfare Board, suitable to all concerned. More recently a parallel plan has been reached between the County Society and the State Board of Children's Guardians.

In January, the meetings was a joint one of the Morris County Medical Society and the Morris-Somerset Pharmaceutical Association. The speakers were George Carden, M.D., of Presbyterian Medical Center, and Tom Rowe, Dean, Rutgers College of Pharmacy. At our February meeting our speaker was Tertius Martin, M.D., of New York City.

Attendance this year has increased appreciably due to the return of men from service and to new members. Membership in Morris County Society is approximately 145. We believe our meetings will continue to be numerous with our present increased membership and more scientific programs indulged in.

OCEAN

Raymond A. Taylor, M.D., President, Lakewood

The Ocean County Medical Society has enjoyed a very successful year for 1946. During this period several projects have been initiated, the Ocean Plan for Examination of Veterans and the Cancer Control being most noteworthy. Monthly scientific meetings have been the usual order, most of them in conjunction with dinner meetings at the hotels and restaurants in the county. New members have been added to the list, along with the returning of members who had been recently released from service. Whereas the past year has been gratifying in the amount of work accomplished, we are looking forward to the coming year with all expectations of exceeding all the work of previous seasons.

PASSAIC

Harry Wolfson, M.D., President, Paterson

The current year draws to a close with the knowledge that practically all our physician-veterans have returned to civilian practice from the armed forces. One-third of our membership answered the call to duty and we are honored by their record. We are giving them any assistance possible in re-establishment of their practices and in a number of instances have been able to aid in securing suitable offices and homes.

Our Program Committee has worked diligently and faithfully and we have been fortunate in the speakers obtained to address us at our regular monthly meetings. These speakers of outstanding ability in their various fields of medicine have covered the following subjects:

1. Differential Diagnosis of Low Back Pain.
2. Chemotherapy and Antibiotics.
3. Differential Diagnosis of Chest Diseases.
4. Communicable Diseases.
5. Common Neuropsychiatric Disorders and Their Treatment.
6. Common Complications of Diabetes.

7. Differential Diagnosis of Early Cancer of the Stomach.
8. Diagnosis and Treatment of the Common Skin Disorders.

Extensive plans are being formulated for a Centennial Celebration of our Passaic County Medical Society on May 20 and 21, 1947. The society was actually 100 years old in 1944, but due to the fact that so many of our members were in the Armed Forces it was decided to postpone our "Centennial" until this time when all can attend. Scientific sessions are scheduled to be held in the auditorium of the State Teachers College in Paterson in the afternoon and evening of May 20th and in the afternoon of May 21st. It is also planned to have a dinner and scientific session in the evening on May 21st, arrangements for which have not as yet been completed. The scientific sessions will be a symposium on heart disease and hypertension.

Our Cancer Committee has been active during the year. Plans have been completed for a Passaic County Medical Society Cancer Week program, to be held in Paterson during April. Excellent speakers have been secured for evening meetings for the profession to be held in St. Joseph's Hospital. Daily round-table discussions, motion pictures, and exhibits for the profession plus a full program for the laity including exhibits, motion pictures, and speakers to be given daily at the Public Library on Broadway, Paterson. The Passaic County Chapter of the American Cancer Society, The Women's Field Army, our Woman's Auxiliary and the Red Cross will participate to make this program a success. The committee was called upon to work in conjunction with the local chapter of the American Cancer Society in an advisory capacity for the proper distribution of their funds in our county. As a result the hospital tumor clinics have been improved by the purchase of needed equipment and material and needy cancer patients aided by the establishment of a Radon and Radium Fund.

Plan for the examination of veterans was incorporated in Passaic County. Arrangements have been made with local hospitals to carry out the work and the organization is now complete. The first authorizations have been received from the Veterans Administrations and the examinations will be begun in the near future.

The Cardiac Committee in conjunction with the Passaic County Tuberculosis and Health Association sponsored a National Heart Week in Passaic County to inform and educate the public concerning Heart Disease, February 9 to 15. National Heart Week was inaugurated by the American Heart Association who are now conducting the most comprehensive assault on Heart Disease ever waged in this country.

Our Maternal Welfare Committee has continued with its excellent project "The Rh Negative Blood Donors Club". This club was organized in 1944 and has been instrumental in saving the lives of many babies and mothers. During the year the Club has increased its membership by 25, making the total now 75, all willing to aid in these emergencies.

Our monthly *Bulletin* has been published regularly with news of local, state and national interest to our members. Dr. Joseph E. Mott, our Editor-in-Service, returned during the year and has resumed his practice as well as the editorship of the *Bulletin*. I wish to express the appreciation of the society to Drs. Rothman and Budd who carried on during the time the regular members of the *Bulletin* staff were in Service and to Dr. Mott who has so willingly and ably resumed the task.

Nine Active and nineteen Associate members have been elected during the year with ten Active, one Courtesy, and ten Associate membership applications pending at this time. We report with regret however the loss by death of four of our members: Drs. William W. MacAlister, Howard L. Maps, Harry Jarmulowsky and Albert Ward.

The society has been kept informed of all pending legislation through the Welfare Council, the Legislative Committee and the publication in our *Bulletin* of all bills pertaining to medical practice and to public health as well as the progress and results of hearings and conferences on these measures.

We commend our Woman's Auxiliary for their splendid record. We have one of the most active and capable Auxiliaries in the State and are proud and pleased to give them aid and counsel whenever called upon. They have conducted many worthy projects of health education and public relations.

I wish to express my deep appreciation to the officers of the society, the members of the welfare council, and to the chairmen of our various committees for their attendance at the meetings and for their active interest and participation in the affairs of our society.

UNION

Elton W. Lance, M.D., President, Rahway

To celebrate the homecoming of our veteran physicians we held our first postwar outing at the Plainfield Country Club in September with 128 members present. Everyone voted to hold an outing of this kind every year. Today we are happy to report that we have only one member still in service and he is stationed in Bayonne. Of the 145 members to return, a few have moved or transferred their memberships temporarily but they are keeping their contacts with us and we will be glad to see those who return to practice again in Union County.

It has been most gratifying to see the increase in the attendance at the meetings and particularly the interest shown in the affairs of the Society by the returned members. We shall try to make the meetings interesting and we hope that all of the doctors will take an active part in the affairs of the society for it will be only as strong as the members make it by each doing his share in promoting the interests of his profession.

The *Bulletin* has steadily increased its circulation in the past five years and by request, it is mailed to readers in fifteen states, England and France. In that same time, advertising has trebled and the net income now covers the cost of one of our administrative departments. We could not however publish our *Bulletin* without the fine cooperation of our printers and their staff. To the Henry Cook Printshop we wish to express our thanks for their untailing help and interest for the past six and a half years, particularly during the war when they had many problems in getting out their work but they always had our *Bulletin* ready on time.

The Woman's Auxiliary was inactive for a long period because many of the members were away during the war or active in various war projects at home. The first postwar meeting was held in Plainfield in September with 67 members and guests present. Mrs. F. G. Wandall, President of the State Auxiliary, Dr. H. D. Corbusier, Chairman, Woman's Auxiliary Committee, Union County Medical Society, and Miss Rogers were guests at the luncheon. A very interesting and instructive program has been planned by Mrs. E. Milton Staub, president and her program committee. The Society is indeed pleased to have the Woman's Auxiliary active again and we will be glad to assist the members in any way possible to help them continue.

The Society has for years been acutely aware of the need of facilities for the long term ill patient and for contagious diseases but lack of building material and lack of personnel has made any increase in present facilities impossible. However, two projects have been undertaken this year which will be of great assistance in relieving part of this burden. Several years ago a survey of the county showed the great need for a cardiac clinic and last year while Dr. Phelan was president, a joint cardiac committee was organized with the endorsement of the Society to study the problem. The committee was formed with representatives from the County Society, the Union County Tuberculosis League and the Visiting Nurse Association of Eastern Union County. St. Elizabeth's Hospital generously offered space for the clinic, the VNA furnished nursing and follow-up personnel and the Tuberculosis League is in charge of the educational program. When it was found that a fluoroscope was needed, the Soroptimist Club of Elizabeth offered to pay for a machine. Three times the number of physicians needed volunteered to serve and so great has been the interest of the staff members, the interns and nurses that the hospital has recently added a Department of Cardiology with Dr. Harry Bloch as Chief Cardiologist. Patients needing long term bed care and rehabilitation are sent to Bonnie Burn Sanatorium where facilities have been made available for twenty patients. Nine patients are there now. Since the clinic opened last April 108 new patients have been examined and there were 240 revisits. The clinic is open on Friday mornings.

The Union County Chapter of the American Cancer Society was formed recently and Dr. Wuester who is Chairman of our State and County Cancer Committees was appointed Medical Director. The other members of our Cancer Committee are medical advisers to the Chapter and your Executive Secretary is a member of the Board of Directors. Union County has been very fortunate in having the Green Memorial Tumor Clinic, Elizabeth General Hospital, for several years and the work of that clinic is too well-known to report on further at this time. The County Society through its Cancer Committee will continue to cooperate in the program planned by the Cancer Committee of the State Society.

Last summer the need for hospitalization of poliomyelitis patients in this County was again stressed and although one of our hospitals fur-

nished emergency care for the season, it was decided that a more permanent arrangement must be made. St. Elizabeth Hospital made available space for one ward and the Union County Chapter of the National Foundation for Infantile Paralysis is providing $20,000 for the necessary equipment. The ward will be ready within a few months and when not in use as a poliomyelitis unit it will serve as a ward for contagious diseases.

When requested to cooperate in setting up examination clinics for veterans claiming disability, the County Society unanimously agreed to assist The Medical Society of New Jersey in carrying out the program. The Union County Plan for Veterans Medical Care was incorporated several weeks ago and the contract between the Board of Trustees of the Plan and the VA is now in Washington. When the signed agreement is received, the first clinic will be established immediately. Dr. Yorke, the Liaison Officer with the Veterans Administration, is one of the our members and has been appointed Secretary-Treasurer of the Plan. He has been most helpful to us in planning our program.

Members of the Public Relations Committee and other officers of the Society held a most interesting conference with several prominent newspaper men connected with three well-known papers in the county to discuss our mutual problems. As a result of that meeting we feel that there is a new understanding between the press and our Society and we deeply appreciate the fine cooperation we receive from all of the papers throughout the county.

We were indeed proud that one of our members, Dr. Charles H. Schlichter, received the Ill Award this year and that nearly seventy members of the Society received Selective Service medals for their years of service with the draft boards in Elizabeth and neighboring communities.

We have added this year, committees on Cancer, Mental Hygiene and (by request from the organization) an Advisory Committee to the Elizabethtown Chapter of the American Red Cross.

Although every committee is not mentioned by name in this report, all have done excellent work and several of the projects that they have started this year will be completed shortly.

The Executive Office staff has carried out the regular routine work that must be done to help the Society perform its duties as smoothly and efficiently as possible. Information has been requested regarding positions in industry, the VA and nursing and in several instances we have been able to be of assistance. Telephone requests for information on many subjects has been supplied and the most distant call for information was received from Lima, Peru. Material has been furnished to writers, students and speakers on compulsory health insurance, legislation, the long term ill patient, prepayment health insurance, group practice, etc. We also furnished several speakers on the above subjects to veterans organizations, the PTA, a service club for women and other lay groups interested in medicine. The Executive Secretary as the representative of the Society serves as a committee member in several organizations interested in health and welfare work and is therefore able to keep the officers and members informed on matters of interest to them.

I wish to thank the officers of the Society and the chairmen of the various committees for their cooperation, their interest in all of our projects and assistance in the affairs of the Society.

CIVIL SERVICE VACANCIES FOR M.D.'s

Many vacancies now exist in the federal medical service, for which salaries of $4100 to $5900 a year are being paid. Age limit is 62 years. Information and application forms are obtained at any first-class post office in New Jersey. Closing date for filing application is April 22.

The vacancies exist in various agencies throughout the United States including the Indian Service, the Panama Canal Service, and the U. S. Public Health Service. There is need for general practitioners and for specialists in all fields. No written examination is required. Applicants are rated on the basis of experience, education and training.

BOOK REVIEWS

Metastases. Malford W. Thewlis, M.D. Charlotte Medical Press, Charlotte, N. C. 1944.

At the beginning of the first chapter, the author quotes the definition of metastasis as "the transfer of a disease process from a primary focus to a distant one by the conveyance of the causal agents through blood-vessels or lymph vessels". His plan is to present in concise tabular form the metastases as found in the various parts of the body and their spread.

Had this plan been followed consistently, this would be a most valuable book, but unfortunately, in many cases, various manifestations of disease are mistaken for metastases. For example, under the heading "Anemia, erythroblastic (Cooley's syndrome)", we find:

A. (Type or site of primary lesion) Spleen.
B. (Source of metastases) from—
Infantile leishmaniasis
neoplasms
rickets
C. (Location of metastases)
(The more common ones are italicized under these headings)
To: Clavicle *long bones,* scapula, *skull, spleen.*

Erythroblastic anemia is now known to be a dyscrasia resulting mostly from a maternal-fetal blood incompatibility. The bony and splenic changes are not metastatic but are manifestations of the attempt on the part of the body to counteract the blood destruction by hyperfunction.

Numerous other errors are found. For instance, under "Choriocarcinoma", the most frequent sites of primary lesions are noted as "Brain, uterus". Did the author confuse the term "Choriocarcinoma" derived from primitive trophoblastic cells in the placenta or testis, with "Carcinoma of the Choroid plexus"?

Camille Mermod, M.D.

Textbook of Gynecology. Fifth Edition. By Arthur Hale Curtis, M.D. Pp. 755 with 455 illustrations. Philadelphia, W. B. Saunders Co., 1946. $8.00.

Curtis' Textbook has been for a long time the outstanding textbook for the student as well as for the resident physician. This entirely revised and partly rewritten edition is remarkable for concise diction, that was essential in covering such extensive material as present-day gynecology has to offer. I wish to call particular attention to the chapters on endocrines and on ovarian tubors.

Last and not least I would like to emphasize our appreciation for the excellent first chapter on the anatomy of the subject. It might be interesting to add in a separate chapter the operative technic following the anatomical chapter some day. A wonderful book from A to Z altogether.

Herbert Steiner, M.D.

National Formulary VIII. Prepared by American Pharmaceutical Association. Mack Publishing Company, Easton, Pa., 1947. $7.50.

The new giant-size National Formulary includes official specifications for many widely used drugs not previously listed in the Pharmacopoeia nor in earlier editions of the Formulary. An innovation in this issue is a marginal index which permits rapid ready reference to the material. For the first time in its history, English titles are given priority and the alphabetical arrangement of the monographs is by English rather than by Latin captions. The book enjoys wide legal acceptance and is officially recognized as a source of drug standards in the Federal and State Food and Drug Laws. The Formulary became official on April 1, 1947.

Electrocardiography in Practice. By Ashton Graybiel, M.D., and Paul D. White, M.D., with the Assistance of Louise Wheeler, A.M., and Conger Williams M.D. 2nd ed. Pp. 458; 323 ills. Philadelphia: W. B. Saunders Company, 1946. $7.00.

Modern concepts of electrocardiography interpretation are covered in a panoramic style in this book. It is unique in that it represents an attempt to correlate graphic with clinical findings. A case record accompanies each illustration. Interpretation is presented first; the clinical findings follow, and finally a brief comment is added. In a presentation of this type, it is obviously impossible to enter into a detailed analysis of the electrocardiogram or to give consideration to underlying mechanisms. Therefore, it will probably not appeal to the beginner in this field. However, it is admirably suited to the needs of the student. It also may be read with profit by the advanced cardiologist.

The book is divided into five parts and an appendix. The first chapter is devoted to a consideration of physiologic principles and technic. The Einthoven triangle hypothesis is adequately covered and the confusion of terms between "instantaneous electrical axis" and the more commonly used term "electrical axis" is clarified. The section on precordial leads is an excellent example of clear writing. The influence of the position of the exploring and of the indifferent electrodes on the form of the precordial curve is stressed. One of the most important practical points in electrocardiography is the ability to recognize normal variants. This is properly emphasized; indeed the entire second chapter is devoted to it. The arrhythmias are sketchily covered in Part Three. Most readers will probably disagree with the interpretation of figures, purporting to illustrate auricular extrasystoles, and will prefer to call them atrionodal extrasystoles. Part Four is concerned with a description of electrocardiographic patterns. The tracings which illustrate myocardial infarction are outstanding. In the appendix there is a brief introduction to the theory of unipolar leads. This is an excellent review of a subject about which there is widespread misunderstanding.

This book is enthusiastically recommended.

Ralph Miller, M.D.

Active Psychotherapy, by Alexander Herzberg, M.D. New York, Grune and Stratton, 1946, 152 pp. $3.50.

In this monograph Dr. Herzberg has attempted to supply a need that many physicians, psychiatrists and analysts, including early disciples of Freud, felt was lacking in psychoanalysis:—active treatment. The philosophy of medicine itself is oriented toward active measures, and psychiatrists are familiar with the anxiety-driven demands of patients that the active approach be utilized instead of the frequently passive interpretive one. Dr. Herzberg's active approach applies "psychoanalysis" only to find out the unconscious causes of the neurosis, since very little interpretation is made. His main reliance is upon suggestion, persuasion, authority, admonition, manipulation of the environment and especially the direction of "tasks" against something the patient fears or against a bad habit. These procedures are the very ones that most patients have used themselves and expect the doctor to use. In truth many psychiatrists will admit having applied these measures for "superficial psychotherapy." There is a place for such treatment; intellectual honesty, however, indicates that the patient is helped, not by his understanding of the conflicts involved, but rather through the allaying of anxiety which may return whenever the therapist's voluntary assumption of the authoritative, protective role is questioned.

Morton M. Stern, M.D.

Diseases of the Skin for Practitioners and Students, by George Clinton Andrews, M.D. 3d ed., with 971 illustrations. Philadelphia, Saunders, 1946.

Andrews' new edition represents a complete revision. The book has been cut down; many unessential details (and the much too long discussion of theory, which filled the earlier editions) have been omitted. Thus the volume is more practical and briefer and, therefore, better as a quick reference book for the general practitioner and student. The illustrations are excellent and refreshingly different from the old standbys of the older texts. At least sixty new diseases are mentioned, although their discussion is, in too many cases, curtailed. The description of ring-worm of the scalp is particularly good and timely because of the current epidemic.

All the new drugs, including penicillin, are mentioned in the treatment section. The paragraphs on the pathology are too brief to be of any value to the specialist. The only serious criticism is directed toward the discussion of neuropsychiatric aspects of dermatology. Many leaders in this field are beginning to stress the role of the psyche in skin diseases. Andrews' brief description of one and one-half pages is insufficient.

Bart M. James, M.D.
Jacob Bleiberg, M.D.

The Extremities, by D. P. Quiring B. A. Boyle, E. L. Boroush and B. Lufkin. 117 pp., with 106 illustrations. Lea & Febiger, Philadelphia, 1945.

This scholarly contribution will be of great help to the student and surgeon who wishes a mental picture of the exact location of the muscles of the extremities, their nerves, arteries and the muscle points. It will also serve a good purpose in acquainting the reader with the functions of each individual muscle of the extremities. The localization of each individual motor point for each muscle will be of great assistance to a practitioner who wishes to test the functions electrically in that he will know immediately where the muscle points are.

David S. Eisenberg, M.D.

Jewish Luminaries in Medical History and a Catalogue, by Henry Friedenwald, M.D. 196 pp, 3 plates, published by Johns Hopkins Press, Baltimore, 1946. $3.00.

This is chiefly a reference catalogue of books and articles pertaining to the role of Jewish scientists and their contributions to medicine through the ages. In all, there are almost a thousand references. These are prefaced by a reprint of an address delivered at the Johns Hopkins University by the author, in which he gives the highlights of the subject starting with hygienic and dietary laws and the care of the sick as gleaned from the Talmud, the Old Testament and the Bible. Of special importance are the detailed instructions in the diagnosis, treatment and isolation of the lepers and the recognition of contagious diseases by the ancient Hebrews with their strict injunctions as to the isolation of the sick. This early medical knowledge greatly influenced Arabic medical literature and later medieval medical writings of Italy, Spain and England.

Of the Italian Hebrew medical authors, the most famous was Donnolo in the tenth century; another scholar, Isaac, born in Egypt in 850, became distinguished as an oculist and later wrote many famous medical and philosophical works; the one on "Fever" was translated into many languages and was included in medical libraries throughout the world for many centuries after.

Another famous physician, Maimonides, was born in Spain in 1135. His family was forced to flee because of persecution of Jews in Spain and after many wanderings he settled in Egypt, where he became court physician and wrote many treatises, which are still considered as classics.

Another important medical author was Villalobas, born in Spain; his most important writings were on bubonic plague and syphilis published in 1489. And so through the centuries, numerous distinguished Hebrew physicians continued to contribute towards the progress of medicine. This book brings the list up to Paul Ehrlich, whose researches revolutionized our knowledge in hematology, and who in 1910 announced his great discovery of the treatment of syphilis with arsphenamine.

Rita S. Finkler, M.D.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **April, 1947** **No. 4**

AMONG community welfare agencies, hospitals have an important place and are a proper concern of every good citizen. The physician, however, is even more immediately involved in hospitals and their policies. The hospital occupies a necessary and vital place in his professional activities, so that proposed changes in hospital procedures and activities merit and receive his closest scrutiny and informed judgment. The present drive to popularize routine chest X-rays for all patients admitted to general hospitals was launched by physicians whose only interest was the protection such a measure affords both to patients and to hospital personnel.

THE OPPORTUNITY

Tuberculosis, which remains a major health problem all over the world, has been under concentrated attack in this country for over 40 years. The greatest effort ever made to eradicate tuberculosis in livestock in the United States was begun about 1900. The result is that today the milk we drink comes from tuberculosis-free dairy herds and our meat comes from non-tuberculous animals.

Viewed from the standpoint of all humanity, this remarkable achievement is little more than an impregnably secured beachhead; but for Americans it has meant almost complete elimination of all human forms of bovine tuberculosis (largely tuberculosis of the bones). Ultimately other countries must also reduce animal tuberculosis.

Today, hospitals are participating in the greatest direct effort ever made to eradicate tuberculosis in humans. This movement began rather slowly about 20 or 25 years ago with tuberculin testing programs for selected groups. This was accompanied by construction of numerous sanatoriums to care for discovered cases. Soon it was learned that physical diagnosis would not discover early cases, but that the X-ray could. There has been real progress. National tuberculosis mortality rates have declined and some areas have achieved mortality lows which were not considered possible 40 years ago.

Despite all this, it was not until about ten years ago that the prospect of complete eradication became a forseeable probability. The earlier programs, depending on tuberculin testing, physical diagnosis and limited use of the X-ray, were too cumbersome and expensive for universal coverage and diagnosis of cases in their early stages. These handicaps were overcome by the development of photofluorographic X-ray equipment and there now appears to be justifiable optimism toward the problem of tuberculosis eradication.

The Council on Professional Practice of the American Hospital Association believes that the immediate need is to extend the practice of routinely X-raying chests. This should be done in many different population groups, but the council is, of course, primarily concerned with the hospital program. A few statistics and facts may be worth repeating.

Hospital admissions now exceed 16,000,000 a year. There are other undertermined millions who are seen in outpatient clinics. These two groups lend themselves to routine radiography; they are in hospitals which have the X-ray equipment and the specialists; there is a minimum of inconvenience to the patient; there is a minimum of expense to the procedure; the percentage of cases found is higher than in other large cross sections of the population. Furthermore, many of these persons would not be reached by programs directed at industrial or other population groups. Finally, this is one of the largest organized groups available for routine programs.

Hospitals which routinely X-ray chests of admissions, outpatients and employees give additional service to their patients and provide a new pro-

tection to the hospital. Infectious cases may be segregated from other patients; the employee knows with which patients he must use added precautions to protect himself; in up to ten per cent of patients non-tuberculous conditions may be revealed. It is not intended here to exhaust the arguments in favor of routine chest radiography in hospitals. Those described are important enough to justify the procedure, if the routine is practicable—administratively and economically. It is noteworthy that the Council program stresses practicability rather than theory.

Two years ago the Council surveyed all hospitals to determine the extent of routine radiography. Of 104 hospitals reporting programs, further checking suggests that only a moderate per cent had a routine considered adequate today. On the other hand, a few weeks ago at a regional hospital meeting a dozen or more administrators indicated their hospitals are now X-raying chests routinely. In one state two photofluorographic units have been purchased by local tuberculosis associations and placed in hospitals, and four more are on order, or have had funds earmarked for the purpose. The U. S. Public Health Service has approved, or will approve, funds for state and local health departments with which to place several hundred X-ray units in hospitals. Many hospitals are setting up the programs on their own or other resources.

Hospitals generally are now much more interested than they were a few years ago in making their facilities available, not only for the care of tuberculosis cases, but for other long-term treatments, such as those required for psychiatric patients and convalescents. It has been difficult to increase this type of service because of crowded conditions in hospitals.

The institution of case-finding routine radiography by hospitals, however, will bring general hospitals face to face with the necessity of providing facilities for temporary handling of some of the discovered cases.

Routine chest X-raying should not be deferred simply because of the fact that cases of tuberculosis will be discovered. These patients are in hospitals for other reasons in the first place. Failure to discover tuberculosis results in these undiagnosed cases of tuberculosis exposing other patients and employees to tuberculosis. Until new construction permits adequate care for tuberculosis itself, hospitals should be able, with the aid of the manual "The Management of Tuberculosis in Hospitals,"* to accept with safety tuberculosis patients for non-tuberculosis treatment.

Human tuberculosis is under the most severe attack ever directed at it. The best thinking today appears to be that eradication will be achieved only after a long pull; that more intensive discovery programs will continue to increase the known cases for years to come; that the sensible course is to create the programs and facilities necessary now to maximum discovery and adequate treatment.

Many national, state and local organizations are coordinating their efforts to eliminate this disease. The hospital has a dominant part in the program. It can become a major case-finding agency by routinely X-raying the chests of all patients on admission, all outpatients and all employees.

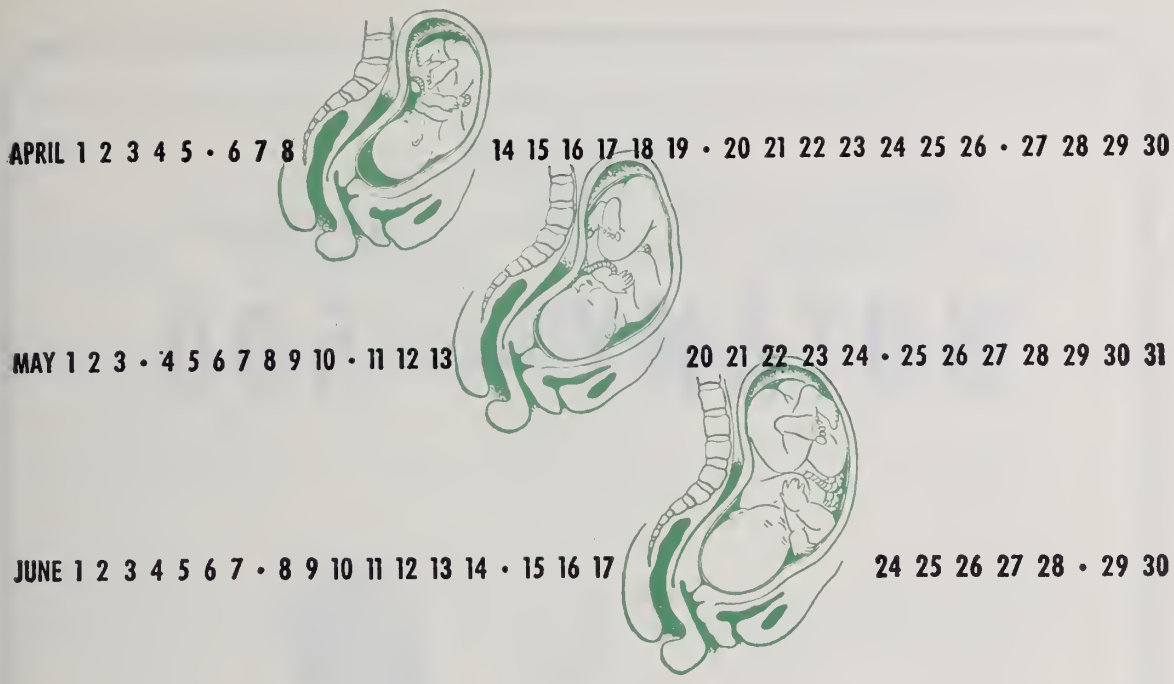
The Opportunity, Robin C. Buerki, M.D., Hospitals, August, 1946.

* Published by the American Hospital Association, Revised Edition, 1946.

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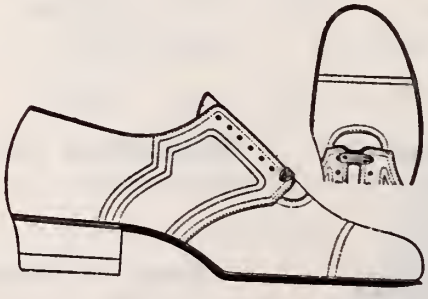
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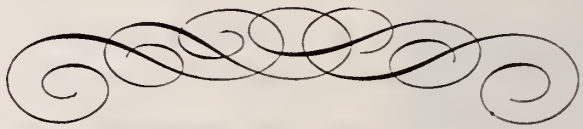
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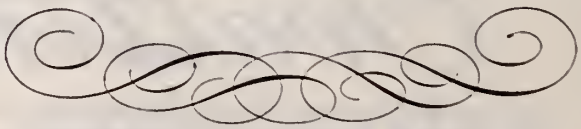


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*Feinberg, S. M.: J.A.M.A., 132: 703 (Nov. 23) 1946.

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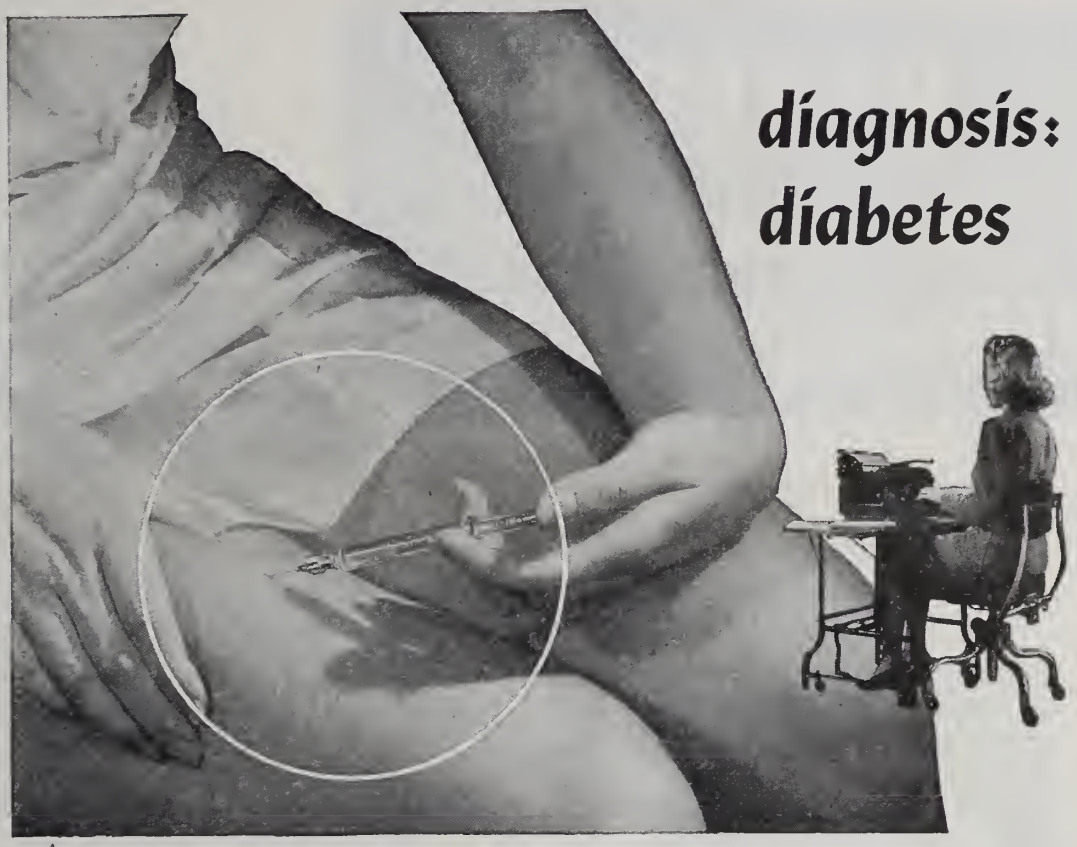
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1. Bull. N. Y. Acad. Med. 18:497, 1942. 2. J.A.M.A. 132:558, 1946.



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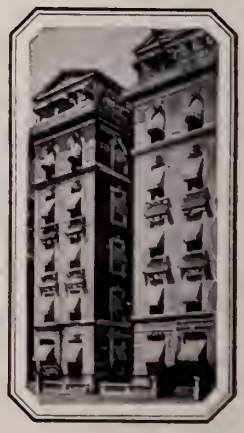
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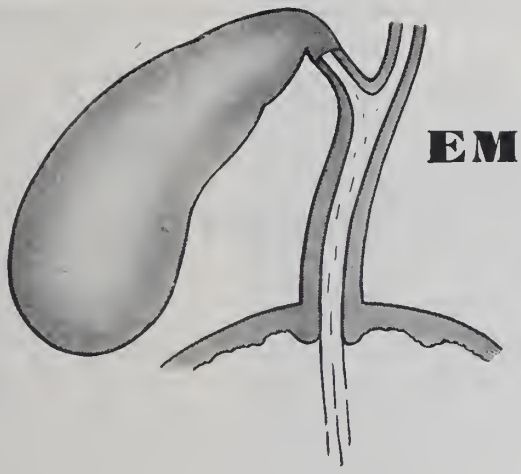
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. . . dental cavities twice as frequent in 5 to 15-year old children not on vitamin D as in those receiving it.[4]

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1. Levy, J. and Silver, H. B.: Arch. Ped., 56:96-105 (Feb.) 1939.

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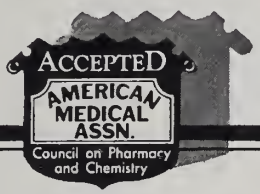
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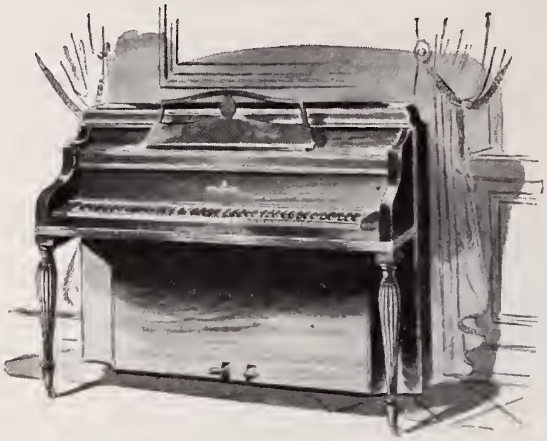
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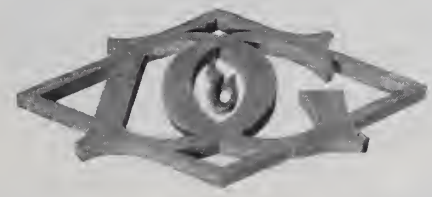
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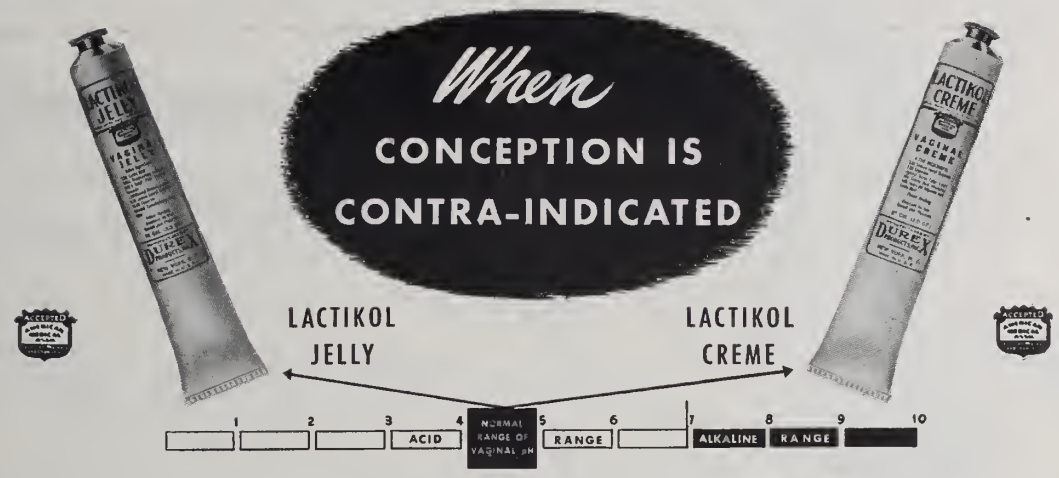
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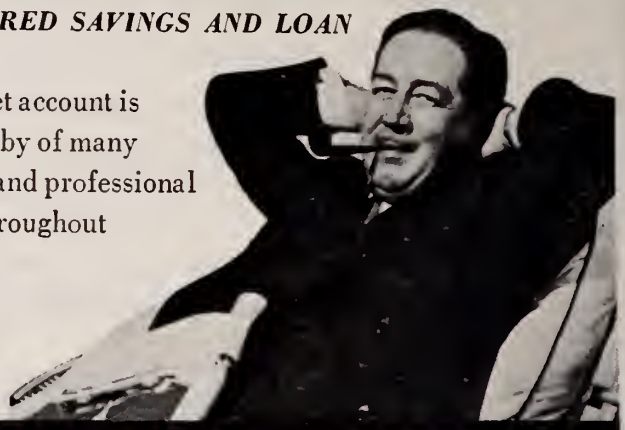


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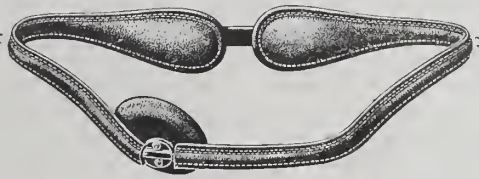
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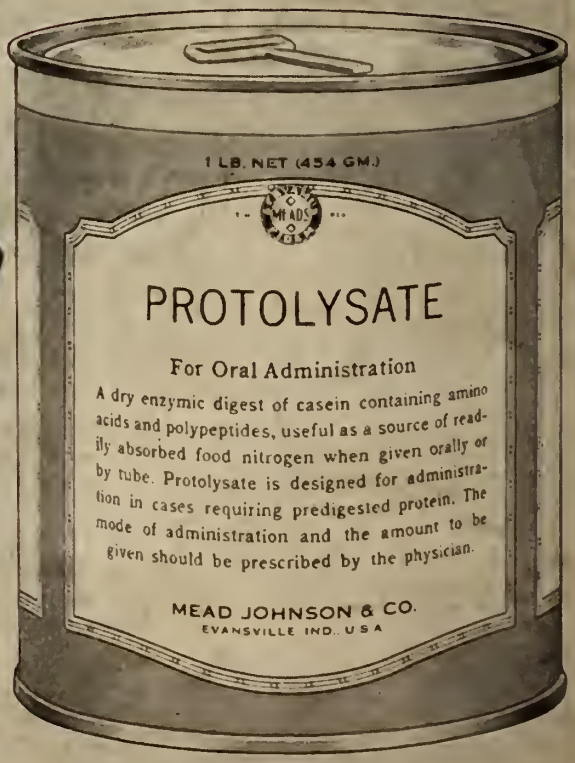
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Fellows and Members

of

The Medical Society of New Jersey

NEW JERSEY DOCTOR'S ALMANAC--1947

Supplement to The Journal of The Medical Society of New Jersey, April, 1947

Supplement to The Journal of The Medical Society of New Jersey, April, 1947

OFFICIAL LIST OF MEMBERS

OF

THE MEDICAL SOCIETY OF NEW JERSEY

FOR THE YEAR 1947

FELLOWS

"THE FELLOWS ARE THE EX-PRESIDENTS OF THE SOCIETY." (Constitution, Article IV. Section 2-a)

Year of Election

1. 1766—Robert McKean, Perth Amboy, 1732-1767
2. 1767—William Burnet, Newark, 1730-1791
3. 1768—John Cochran, New Brunswick, 1730-1807
   1769—John Cochran, No. 3, reëlected
4. 1770—Nathaniel Scudder, Freehold, 1733-1781
5. 1771—Isaac Smith, Trenton, 1740-1807
6. 1772—James Newell, Freehold, 1725-1791
7. 1773—Absalom Bainbridge, Lawrenceville, 1742-1807
8. 1774—Thomas Wiggins, Princeton, 1731-1801
9. 1775—Hezekiah Stites, Cranbury, 1726-1790

No formal meetings 1776-1780 on account of the War of the Revolution.

1781—James Newell, No. 6, reëlected

10. 1782—John Beatty, Trenton, 1749-1826
11. 1783—Thomas Barber, Matawan, 1730-1807
12. 1784—Lawrence Vander Veer, Roycefield, 1740-1815
13. 1785—Moses Bloomfield, Woodbridge, 1729-1791
    1786—William Burnet, No. 2, reëlected
14. 1787—Jonathan Elmer, Bridgeton, 1745-1817
15. 1788—James Stratton, Swedesboro, 1755-1812
16. 1789—Moses Scott, New Brunswick, 1738-1821
17. 1790—John Griffith, Rahway, 1736-1805
18. 1791—Lewis Dunham, New Brunswick, 1754-1821
19. 1792—Isaac Harris, Middlesex County, 1741-1808

No elections held in 1793 and 1794 because quorum not present.

20. 1795—Elisha Newell, Allentown, 1755-1799

No formal meetings 1796-1806 owing to an attempt to establish a rival society in Eastern New Jersey.

21. 1807—Jonathan F. Morris, Somerville, 1760-1810
22. 1808—Peter I. Stryker, Somerville, 1766-1859
23. 1809—Lewis Morgan, Rahway, 1757-1821
24. 1810—Lewis Condict, Morristown, 1773-1862
25. 1811—Charles Smith, New Brunswick, 1768-1848
26. 1812—Matthias H. Williamson, Elizabeth
    1813—Matthias H. Williamson, continued for second year
27. 1814—Samuel Forman, Freehold, 1764-1845
28. 1815—John Van Cleve, Princeton, 1778-1826
    1816—Lewis Dunham, No. 18, reëlected
    1817—Peter I. Stryker, No. 22, reëlected
    1818—John Van Cleve, No. 28, reëlected
    1819—Lewis Condict, No. 24, reëlected
29. 1820—James Lee, Newark
30. 1821—William G. Reynolds, Manalapan

Year of Election

31. 1822—Augustus R. Taylor, Somerville, 1782-1840
32. 1823—William B. Ewing, Greenwich, 1776-1866
    1824—Peter I. Stryker, reëlected. Also served 1808 and 1817.
33. 1825—Gilbert S. Woodhull, Manalapan, 1794-1830
34. 1826—William D. McKissack, Millstone, 1781-1853
35. 1827—Isaac Pierson, Orange, 1770-1833
36. 1828—Jephtha B. Munn, Chatham, 1780-1863
37. 1829—John W. Craig, Somerset County, 1795-1871
    1830—Augustus R. Taylor, No. 31, reëlected
38. 1831—Thomas Yarrow, Sharptown, 1778-1841
39. 1832—E. FitzRandolph Smith, New Brunswick, 1786-1865
40. 1833—William Forman, Monmouth County, 1796-1848
41. 1834—Samuel Hayes, Newark, 1776-1839
42. 1835—Abraham P. Hagerman, Somerset County
43. 1836—Henry Vander Veer, Somerville, 1792-1874
44. 1837—Lyndon A. Smith, Newark, 1795-1865
45. 1838—Benjamin H. Stratton, Mt. Holly, 1804-1875
46. 1839—Jabez G. Goble, Newark, 1799-1859
47. 1840—Thomas P. Stewart, Hackettstown, 1798-1846
48. 1841—Ferdinand S. Schenck, Six Mile Run, 1790-1860
49. 1842—Zachariah Read, Mt. Holly, 1808-1879
50. 1843—Abraham Skillman, Bound Brook, 1796-1862
51. 1844—George R. Chetwood, Elizabeth, 1802-1885
52. 1845—Robert S. Smith, Bound Brook, 1800-1874
53. 1846—Charles Hannah, Deerfield, 1782-1857
54. 1847—Jacob T. B. Skillman, Woodbridge, 1794-1864
55. 1848—Samuel Hayes Pennington, Newark, 1806-1900
56. 1849—Joseph Fithian, Woodbury, 1795-1881
57. 1850—Elias J. Marsh, Paterson, 1803-1850
58. 1851—John H. Phillips, Pennington, 1814-1878
59. 1852—Othneil H. Taylor, Camden, 1803-1869
60. 1853—Samuel Lilly, Lambertville, 1815-1880
61. 1854—Alfred B. Dayton, Middletown Point, 1812-1870
62. 1855—James B. Coleman, Trenton, 1806-1877
63. 1856—Richard M. Cooper, Camden, 1816-1874
64. 1857—Thomas Ryerson, Newton, 1821-1887
65. 1858—Isaac Pierson Coleman, Pemberton, 1804-1869
66. 1859—John R. Sickler, Mantua, 1800-1886
67. 1860—William Elmer, Bridgeton, 1814-1889

Year of Election

68. 1861—John Blane, Perryville, 1802-1885
69. 1862—John Woolverton, Trenton, 1825-1888
70. 1863—Theodore R. Varick, Jersey City, 1825-1887
71. 1864—Ezra M. Hunt, Metuchen, 1830-1894
72. 1865—Abraham Coles, Newark, 1813-1891
73. 1866—Benjamin R. Bateman, Bridgeton, 1807-1883
74. 1867—John C. Johnson, Blairstown, 1828-1907
75. 1868—Thomas J. Corson, Trenton, 1828-1879
76. 1869—William Pierson, Orange, 1796-1882
77. 1870—Thomas F. Cullen, Camden, 1822-1877
78. 1871—Charles Hasbrouck, Hackensack, 1818-1877
79. 1872—Franklin Gauntt, Burlington, 1823-1900
80. 1873—Thomas J. Thomason, Perrineville, 1833-1880
81. 1874—George H. Larison, Lambertville, 1831-1892
82. 1875—William O'Gorman, Newark, 1824-1887
83. 1876—John V. Schenck, Camden, 1825-1882
84. 1877—Henry R. Baldwin, New Brunswick, 1829-1902
85. 1878—John S. Cook, Hackettstown, 1827-1900
86. 1879—Alexander W. Rogers, Paterson, 1814-1905
87. 1880—Alexander N. Dougherty, Newark, 1822-1882
88. 1881—Lewis W. Oakley, Elizabeth, 1828-1888
89. 1882—John W. Snowden, Blackwood, 1823-1888
90. 1883—Stephen Wickes, Orange, 1813-1889
91. 1884—Phanett C. Barker, Morristown, 1835-1903
92. 1885—Joseph Parrish, Burlington, 1818-1891
93. 1886—Charles J. Kipp, Newark, 1838-1911
94. 1887—John W. Ward, Trenton, 1840-1916
95. 1888—H. Genet Taylor, Camden, 1837-1916
96. 1889—Beriah A. Watson, Jersey City, 1836-1892
97. 1890—James S. Green, Elizabeth, 1829-1892
98. 1891—Elias J. Marsh, Paterson, 1835-1908
99. 1892—George T. Welch, Passaic, 1845-1924
100. 1893—John G. Ryerson, Boonton, 1834-1916
101. 1894—Obadiah H. Sproul, Flemington, 1844-1925
102. 1895—William Elmer, Trenton, 1840-1908
103. 1896—Thomas J. Smith, Bridgeton, 1841-1932
104. 1897—David C. English, New Brunswick, 1842-1924
105. 1898—Claudius R. P. Fisher, Bound Brook, 1859-1927
106. 1899—Luther M. Halsey, Williamstown, 1858-1921
107. 1900—William Pierson, Jr., Orange, 1830-1900
108. 1901—John D. McGill, Jersey City, 1846-1912
109. 1902—Edward L. B. Godfrey, Camden, 1850-1913
110. 1903—Henry Mitchell, Asbury Park, 1845-1919
111. 1904—Walter B. Johnson, Paterson, 1852-1922
112. 1905—Henry W. Elmer, Bridgeton, 1847-1907
113. 1906—Alexander Marcy, Jr., Riverton, 1860-1934
114. 1907—Edward J. Ill, Newark, 1854-1942
115. 1908—David St. John, Hackensack, 1850-1917

Year of Election

116. 1909—Benjamin A. Waddington, Salem, 1842-1917
117. 1910—Thomas H. MacKenzie, Trenton, 1847-1920
118. 1911—David Strock, Camden, 1850-1927
119. 1912—Norton L. Wilson, Elizabeth, 1861-1931
120. 1913—Enoch Hollingshead, Pemberton, 1843-1924
121. 1914—Frank D. Gray, Jersey City, 1857-1916
122. 1915—William J. Chandler, South Orange, 1842-1927
123. 1916—Philip Marvel, Atlantic City, 1856-1938
124. 1917—William G. Schauffler, Lakewood, 1862-1933
125. 1918—Thomas W. Harvey, Orange, 1853-1938
126. 1919—Gordon K. Dickinson, Jersey City, 1855-1930
127. 1920—Philander A. Harris, Paterson, 1852-1924
128. 1921—Henry B. Costill, Trenton, 1860-1935
129. 1922—James Hunter, Jr., Westville, 1866-1931
130. 1923—Wells P. Eagleton, Newark, 1865-1946.
131. 1924—Archibald Mercer, Newark, 1849-1931. Resigned.
1924—**LUCIUS F. DONOHOE,** Acting President
132. 1925—**LUCIUS F. DONOHOE,** Bayonne, born 1868
133. 1926—James S. Green, Jr., Elizabeth, 1864-1936
134. 1927—Walt P. Conaway, Atlantic City, 1873-1945
135. 1928—Ephraim R. Mulford, Burlington 1880-1939
136. 1929—Andrew F. McBride, Paterson, 1869-1946
137. 1930—**GEORGE N. J. SOMMER,** Trenton, born 1874
138. 1931—John F. Hagerty, Newark, 1869-1937
139. 1932—A. Haines Lippincott, Camden, 1867-1937
140. 1933—**FREDERIC J. QUIGLEY,** Union City, born 1883
141. 1934—**LANCELOT ELY,** Somerville, born 1875
142. 1935—**MARCUS W. NEWCOMB,** Browns Mills, born 1880
143. 1936—Francis R. Haussling, Newark, 1875-1941 —resigned
144. 1936—**SPENCER T. SNEDECOR,** Hackensack, born 1900
145. 1937—**WILLIAM G. HERRMAN,** Asbury Park, born 1890
146. 1938—**WILLIAM J. CARRINGTON,** Clinton, Iowa, born 1884
147. 1939—**E. ZEH HAWKES,** Newark, born 1865
148. 1940—**WATSON B. MORRIS,** Springfield, born 1878
149. 1941—**THOMAS K. LEWIS,** Camden, born 1887
150. 1942—Ellas J. Marsh, Paterson, 1875-1943
151. 1943—**RALPH K. HOLLINSHED,** Westville, born 1884
152. 1944—**JOSEPH F. LONDRIGAN,** Hoboken, born 1884
153. 1945—**SAMUEL ALEXANDER,** Park Ridge, born 1888
154. 1946—**FRANK G. SCAMMELL,** Trenton, born 1877

The names of living Fellows are in bold face type.

HONORARY MEMBERS

Year of Election

1. 1930—Joseph E. Raycroft, Princeton
2. 1939—Nathan V. Van Etten, New York

Year of Election

3. 1939—Haven Emerson, New York
4. 1945—Lucius F. Donohoe, Bayonne

An Alphabetical List of the Members of The Medical Society of New Jersey

COMPILED MARCH 1, 1947

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

A

ACTIVE MEMBERS

Abarbanel, Milton G. (9)
Abbamonte, Louis W. (7)
Abbott, Charles C. (2)
Abel, Arthur R. (7)
Abel, Henri E. (20)
Abey, William J. H. (11)
Abraham, Albert (14)
Abramo, Anthony (2)
Abrams, Abram B. (7)
Abrams, Henry (11)
Abramson, Solomon (20)
Achtentuch, Herman (16)
Ackerhalt, Martin J. (16)
Ackerman, Arthur F. (20)
Ackley, David B. (11)
Adelman, Benjamin B. (7)
Adelson, Edward T. (7)
Adler, Fritz F. (16)
Adler, Howard E. (12)
Adler, Hubert J. (21)
Adler, Lydia (12)
Africano, Julius V. (9)
Agayoff, John D. (2)
Agnew, Hobart M. (7)
Agolia, Michael W. (9)
Ainsley, H. Bryson (9)
Aitken, Frank J. (6)
Aitken, Herbert M. (19)
Albano, Edwin H. (7)
Albano, Frank J. (7)
Albano, Joseph (7)
Albert, Perry (11)
Albini, Mario J. (9)
Albrecht, William J. (18)
Albright, Louis F. (13)
Alcamo, John H. (7)
Alcaro, Joseph A. (14)
Alexander, John W. (7)
Alexander, Samuel (2)
Alexander, Stewart F. (2)
Alford, Ralph I. (7)
Allan, James S. (7)
Allegrante, Anthony J. (18)
Allen, Arthur A. (16)
Allen, Chester B., Jr. (7)
Allen, Edwin J. (16)
Allen, James M. (16)
Allen, Raymond N. (7)
Allen, Samuel L. (20)
Alling, Frederic A. (7)
Allman, David B. (1)
Alpert, Edward (9)
Alpert, Sidney (15)
Alpren, Bernard F. (16)
Alter, Nicholas M. (9)
Altman, Charles D. (7)
Altschul, Frank J. (13)
Amato, Charles P. (4)
Ambrose, Anthony (7)
Amdur, Louis A. (9)
Anastor, Herbert C. (6)
Anderson, Ethelyn J. C. (2)
Anderson, John F. (12)
Anderson, Reuben M. (2)
Anderson, Richard D. (3)
Anderson, Robert C. (7)
Anderson, William A. (7)
Anderson, William M. (4)
Andrews, Albert G. K. (16)
Andrews, Clarence L. (1)
Andrews, Thomas H. (13)
Andrus, David L. (4)
Angell, Emmett D. (16)
Angelo, Joseph A. (9)
Angioletti, Louis V. (2)
Angus, Leslie R. (4)
Annitto, John E. (9)
Annunziata, Augustine (7)
Anrig, Grace E. (9)
Anson, Leon J. (20)
Anthony, David W. (11)
Antonius, Nicholas A. (7)
Antopol, William A. (7)
Anuario, Charles B. (7)
Apfelbaum, Frederick M. (20)
Applebaum, Irving L. (7)
Applegate, Edward T. R. (11)
Applestein, Robert (11)
Appleton, Ralph (15)
Appold, George D. (2)
Apter, Abraham H. (16)
Arbeit, Sidney R. (9)
Arena, John (9)
Areson, William H. (7)
Aria, Charles J. (9)
Aria, Michael H. (9)
Armstrong, Lorrimer B. (20)
Arndt, Frank R. (9)
Aronis, Harry R. (11)
Aronoff, Herman L. (9)
Aronowitz, Harry T. (9)
Arons, Harry (7)
Artaserse, George V. (9)
Arthur, Frances H. (20)
Asbell, Nathan (4)
Ash, Arthur F. (9)
Ash, Frank W. (16)
Ash, Samuel (7)
Ashley, Harmon H. (11)
Assante, M. Hugo (4)
Aszody, Paul (7)
Athey, Kenneth L. (4)
Atkinson, James Q. (3)
Atkinson, John M. (14)
Atwell, David R. (9)
Atwood, Edward A. (16)
Auerbach, Friedrich (7)
Auriemma, Michele (9)
Austin, Henry J. (11)
Autorino, Ralph R. (7)
Averbach, Jacob (16)
Avery, Philip S. (12)
Axilrod, Maurice H. (1)
Axinn, Charles (20)
Aymar, Dorothy (9)

ASSOCIATE MEMBERS

Adler, Samuel (13)
Allar, Ellis H. (1)
Alonzo, Gerard J. (16)
Alterbaum, George (7)
Amato, John R. (7)
Andrick, Eugene A. (2)
Apple, Stanley B. (11)
Aronsohn, Charles M. (16)
Audi, Eugene H. (2)
August, Jacob (7)

B

ACTIVE MEMBERS

Babbitt, Hugh M., Jr. (20)
Bachmann, William (7)
Bacon, Mary (6)
Bacote, Ernest F. (7)
Baer, Irving (13)
Baeseman, R. Winfield (13)
Bagg, Linus W. (7)
Bahnson, Conrad M. (9)
Bailyn, Emanuel (9)

Baime, Jules E. (7)
Baiocchi, Pascal J. (7)
Baker, Augustus L. (14)
Baker, Banks S. (4)
Baker, Elsworth F. (13)
Baker, Hugh W. (6)
Baker, Maclyn F. (7)
Baker, Maurice E. (4)
Baker, Philip W. (10)
Baker, Raymond D. (20)
Baketel, H. Sheridan (2)
Baldauf, Herman, Jr., (21)
Baldini, Charles F., Jr. (9)
Baldwin, John F. (2)
Balis, Samuel B. (7)
Balles, Edward S. (16)
Balogh, William A. (12)
Balsamo, Anthony J. (9)
Balsamo, Joseph J. (7)
Balson, Zachary D. B. (7)
Balze, Henry R. (2)
Bambara, Aurelius J. (10)
Banker, George T. (20)
Banta, Raymond E. (2)
Barb, Kirk B. (4)
Barbano, Alfred J. (12)
Barbarito, William N. (9)
Barbash, Roslyn H. W. (2)
Barbella, Joseph D. (7)
Barberio, A. Arthur (20)
Barbour, George E. (18)
Barishaw, Samuel B. (9)
Barkhorn, Charles W. (7)
Barkhorn, Henry C. (7)
Barlow, Frank A. (16)
Barlow, G. Barton (2)
Barlow, John D. (11)
Barnard, Frank G. (7)
Barnes, William J. (2)
Barnett, Lester A. (13)
Barnshaw, Harold D. (4)
Barolsky, Benjamin (16)
Baron, Herbert A. (2)
Baron, Leo E. (20)
Barone, Francis A. (9)
Barone, Leo J. (16)
Barr, Joseph (16)
Barrett, John E. (7)
Barrett, Joseph F. (7)
Barroway, James N. (4)
Barrows, Arthur M. (11)
Barry, R. Grant (11)
Bartlett, Clara K. (1)
Bartolini, Frank (21)
Barton, Amy S. (3)
Baruch, Hilde (20)
Baruch, Rudolf J. (20)
Basralian Joseph B. (2)
Bassett, Lavern C. (12)
Bassett, Norman H. (1)
Battaglia, Richard S. (20)
Bauch, Solomon (7)
Baum, Felix (7)
Baum, Lewis F. (7)
Baum, Samuel (7)
Bauman, Everett O. (7)
Bauman, Rush C. (7)
Baxt, Sidney J. (16)
Bayer, Eric C. (2)
Bayer, Harold J. (1)
Bayne, Joseph K. (11)
Bealrsto, Everett B. (11)
Beatty, Hannah J. (10)
Beaver, Jennie D. (14)
Bechet, Paul E. (20)
Becker, C. Frederick (4)
Becker, Frank F. (16)
Becker, George L. (16)
Becker, Leo V. (16)
Becker, Martin (7)
Becker, Sidney D. (13)
Bedrick, John J. (9)
Beer, Sanel (7)
Behrens, Herman H. E. (9)
Beideman, Casper M. (4)
Beir, Ily R. (1)
Beisler, Lawrence G. (20)
Belafsky, Henry A. (12)
Belfer, Jacob J. (11)
Belford, Ralph J. (11)
Beling, C. Abbott (7)
Bell, Horace O. (7)
Bellak, Ellis R. (6)
Bellis, Horace D. (11)
Belott, Louis V. (7)
Ben-Asher, Solomon (9)
Bender, Dorothea A. (20)
Bender, Louis (7)
Bender, Theodore (16)
Bengelsdorf, Aron (7)
Benjamin, Harold C. (9)
Benjamin, Joseph F. (16)
Bensley, Maynard G. (20)
Bentley, David F., Jr. (4)
Benz, Francis J. (14)
Benz, George, L. (7)
Berardinelli, Carmine G. (7)
Berenson, Samuel J. (20)
Beres, Albert J. (2)
Berg, Samuel (7)
Berger, Harold R. (20)
Berger, William A. (7)
Bergin, Joseph V. (16)
Bergman, Meyer W. (7)
Bergmann, Ewald H. (19)
Bergmeyer, Josef T. (9)
Bergsma, Daniel (11)
Berk, M. David (16)
Berke, Raynold N. (2)
Berkhout, Peter G. (16)
Berkow, Samuel G. (12)
Berkowitz, Benjamin (6)
Berlin, Joseph I. (9)
Berlin, Morris R. (7)
Berlin, Walter (9)
Berman, Jacob J. (11)
Berman, Leonard M. (20)
Berman, Sol (20)
Bernard, Richard C. (2)
Bernell, Stanley P. (4)
Berney, Irving (7)
Berney, Ruth V. (7)
Bernhard, William G. (7)
Bernheisel, Louis E. (5)
Bernson, Samuel T. (16)
Bernstein, Arthur (7)
Bernstein, Bertram (11)
Bernstein, Julius (7)
Berry, C. Hartley (20)
Berry, Leonard M. (11)
Bertha, Nicholas A. (14)
Besson, Franklin J. (7)
Betancourt, Raul R. (4)
Betts, R. Winfield (3)
Bew, Richard C. (1)
Beyer, Othmar J. (7)
Beyer, William (2)
Bianchi, Angelo R. (7)
Bianco, John J. (4)
Biber, David (20)
Biczak, Arkad K. (16)
Bigliani, Urban R. (9)
Binder, Charles I. (7)
Binder, Joseph (13)
Bird, Frank L. (14)
Bird, Ivan F. (11)
Birdsall, Clarence A. (7)
Bissett, John V. (7)
Biunno, Anthony J. (7)
Black, LeRoy W. (2)
Black, Maskell B. (8)
Black, Max S. (20)
Blackburne, George (7)
Blackwell, Enoch (11)
Blair, Thomas D. (20)
Blaisdell, C. Byron (13)
Blake, Albert J. (16)
Blake, Dexter B. (14)
Blakey, Abram P. (9)
Blanchard, Charles L. (14)
Blanchard, Kenneth (7)
Blatt, David (20)
Blaugrund, Samuel (11)
Blaustein, Maurice L. (7)
Blauvelt-Wells, Grace B. (2)
Bleasby, Charles B. (2)
Bleiberg, Jacob (7)
Blenkle, Victor A. (2)
Bloch, Harry (20)
Block, Marcus T. (7)
Block, Max (7)
Block, Milton (7)
Bloom, G. Homer (21)
Blumberg, Jack (20)
Blythe, Rowland P. (20)
Bobadilla, Juan E. B. (14)
Bocchini, Joseph A. (7)
Boehm, Herbert (20)
Bohl, Louis J. (16)
Bokor, Emery (7)
Bolanowski, Kasimier J. (20)
Bolten, Bernard (7)
Bonanno, Peter J. (2)
Bongiorno, Henry D. (16)
Bonnet, W. Laurence (11)
Bonomo, Michael J. (7)
Booken, Gerald J. (7)
Bookrajian, Edward N. (9)
Bookstaver, Barnet S. (2)
Booth, Herbert W. (13)
Booth, Walter S. (20)
Booth, William K. (14)
Boquist, Walter A. (21)
Borchek, Arthur R. (9)
Borkow, Philip (14)
Bornstein, David (16)
Bornstein, Paul K. (13)
Borow, Henry (18)
Borow, Maurice (18)
Borrella, Dominic D. (11)
Borrone, Milton G. (9)
Borrus, Joseph C. (7)
Borshaw, Hyman (9)
Borsher, Irving P. (7)
Bortone, Frank (9)
Bosch, Taeke (2)
Boselli, Emile H. (9)
Bossard, Harry B. (21)
Bossone, Joseph E. (13)
Bostwick, Delazon S. (6)
Bostwick, Wallace R. (21)
Botbyl, Burt W. (16)

Botti, John A. (9)
Boudwin, Norman K. (4)
Bourns, Edward G. (20)
Bove, Joseph (7)
Bowen, Robert N. (4)
Bowers, F. Clyde (14)
Bowersox, Clarence A. (8)
Bowles, Harry H. (20)
Bowman, Ned O. (12)
Boyd, John B. (13)
Boyd, Robert P. (20)
Boyd, William B., Jr. (19)
Boyer, Charles G. (10)
Boyer, Paul K. (20)
Boyers, Sidney S. (9)
Boyes, James G. (20)
Boylan, Lawrence B. (16)
Boylan, Matthew E. (9)
Boyle, Francis L. (9)
Bozzi, Robert (7)
Brackett, Elizabeth R. (7)
Bradasch, George A. (9)
Bradford, Stella S. (7)
Bradley, Muriel (7)
Bradley, Robert A. (1)
Brady, Frank J. (7)
Brady, Raymond J. (7)
Brady, Thomas S. (9)
Braitman, Max (9)
Bramble, Halsey S. (17)
Brams, William M. (7)
Brancato, Peter (16)
Brancone, Alphonse M. (16)
Brandman, Otto (7)
Branin, Howard S. (6)
Branon, Mark E. (2)
Brasefield, Edgar N. (21)
Brauer, Charles (9)
Brauer, Selig L. (9)
Braun, David C. (19)
Braun, Gustav A. (7)
Braun, William (4)
Braunstein, Sigmund C. (9)
Braunstein, William P. (9)
Braunwarth, Robert J. (20)
Bray, Willlam E. (3)
Bregman, Alexander (2)
Bregman, Milton (13)
Breitstadt, Charles A. (7)
Brennan, Alfred T. V., Jr. (2)
Brennan, Charles L. S. (4)
Brennan, John P. (4)
Brennan, Ralph J. (2)
Brennock, Thomas McG. (9)
Breslow, Alexander E. (20)
Breslow, Samuel (12)
Brethwaite, Samuel H., Jr. (20)
Breuder, Andrew B. (14)
Brewer, David R., Jr. (8)
Brick, George J. (9)
Brien, William M. (7)
Briggs, Henry (7)
Brim, Anne J. S. (7)
Brindle, Harry R. (13)
Brittain, Elmore G. (18)
Broadnax, Mary E. (7)
Brodkin, Eva T. (7)
Brodkin, Henry A. (7)
Brodkin, Louis A. (7)
Brody, Morton S. (12)
Brogan, Francis B. (16)
Brokaw, Christopher A. (20)
Bromberg, Charles B. (16)
Bronner, Alfred (16)
Brooks, George M. (5)
Brooks, Sidney S. (16)
Brotman, Harry (7)
Brotman, Morton M. (7)
Brower, Francis M., III (8)
Brown, Chester R. (7)
Brown, Chester T. (7)
Brown, Edith L. (13)
Brown, Edward V. (7)
Brown, Frank H., Jr. (20)
Brown, Harold W. (7)
Brown, J. Carlisle (1)
Brown, John L. (2)
Brown, Kenneth G. (13)
Brown, L. Greeley (20)
Brown, Lewis W. (7)
Brown, Stanley L. (4)
Brown, William H. (20)
Browne, George F. (7)
Browning, William J. (4)
Brozdowski, John J. (9)
Brozyna, Mieczyslaw (2)
Brunkow, Charles D. (7)
Bruno, Anthony (20)
Buchanan, Ralph M. L. (21)
Buchanan, Robert W. (20)
Buckley, Jeremiah L. (7)
Buckley, Richard T., Jr. (3)
Buckner, Roscoe W. H. (7)
Budd, J. Reuben (16)
Buermann, August, III (7)
Buermann, Robert (15)
Buffey, Walter H. (20)
Bull, Louis M. (7)
Bull, William J. (7)
Bullen, Victor E. (16)
Bump, Samuel C. (2)
Bunnell, Frederick N. (15)
Burbidge, J. Raymond (11)
Burke, Leonard P. (7)
Burke, Stephen E. (7)
Burkett, Wendell J. (8)
Burkhead, Howard C. (13)
Burn, Victor E. (19)
Burne, John J. (7)
Burnett, Hayes J. (7)
Burnett, Lawrence W. (7)
Burnham, Lyman (2)
Burns, Geoffrey C. H. (2)
Burns, Joseph R. (11)
Burns, Wilmer F. (4)
Burokus, William (2)
Burpeau, William P. (7)
Burrill, Benjamin B., Jr. (7)
Burritt, Norman W. (20)
Burroughs, Edmund W. (11)
Burstein, Frank (7)
Burstein, Leo Q. (7)
Burstein, Rachel (7)
Busansky, Samuel T. (3)
Busch, Herman (7)
Bush, Archer C. (7)
Bush, Ralph K. (4)
Busicco, Philip S. (2)
Butan, Louis (7)
Butcher, Charles (6)
Butenas, Joseph J. (20)
Butler, Samuel S. (4)
Butler, Vincent P. (9)
Butterfield, Arey A. (16)
Buvinger, Charles W. (7)
Byck, Louis (7)
Byer, M. Yale (11)
Byrne, J. Arthur (14)
Byrnes, Elizabeth W. (7)
Bythewood, Alton E., Jr. (7)

ASSOCIATE MEMBERS

Baldwin, Charles H. (1)
Bassett, Samuel (2)
Becker, Meyer (12)
Becker, Sylvia F. (7)
Bednarz, Stephen (2)
Beim, Norbert (16)
Bellucci, Frank D. (7)
Bensel, Arlington, Jr. (7)
Berkow, Borl (12)
Berkowitz, Eva R. (11)
Blasl, Benjamin (7)
Block, Charles (7)
Boyd, James W. (7)
Brandchaft, Bernard (7)
Brescia, James (2)
Brezinskl, Edward J. (12)
Brlll, Robert (7)
Bristol, Frank E., II (12)
Bromberg, Jules H. (7)
Brown, Milton B. (12)
Burch, Reynold E. (7)

C

ACTIVE MEMBERS

Cacciarelli, Robert A. (7)
Caggiano, Anthony P. (7)
Caggiano, John D. (17)
Cahlll, Laurence A. (7)
Calabrese, Dino (2)
Calasibetta, Charles J. (7)
Caldwell, Donald M. (7)
Caldwell, George W. (2)
Caleca, Jack J. (19)
Callahan, Edward J. (20)
Calligaro, Egildo A. (16)
Calvert, William C. (7)
Calvln, Charles H. (12)
Camche, Leo J. (7)
Cameron, Albert (18)
Cameron, Arthur E. (7)
Cameron, C. Paul (5)
Cameron, Edwin A. (7)

Campana, Vincent R. (9)
Campbell, Dorothy C. (4)
Campbell, Everette L. (7)
Campbell, James M. (2)
Campbell, William (7)
Campo, Salvatore T. (8)
Candio, Vincent P. (2)
Cangemi, Vito F. (9)
Cannata, Benjamin (12)
Cannis, John P. (20)
Cannon, Edward A. (9)
Canright, Cyril M. (20)
Cantalupo, Emidio (7)
Cantelmo, Alphonse L. (7)
Cantini, Raphael S. (20)
Capell, Harry H. (16)
Capio, Mario D. (16)
Cappiello, William (7)
Captanian, Aram A. (13)
Caputo, Anthony R. (7)
Carabelli, A. Albert (11)
Carbone, Francesco N. (7)
Carbone, Ralph (2)
Card, Charles F. (20)
Cardinale, Pasquale F. (20)
Cardwell, Edgar P. (7)
Carey, David S. (13)
Caridi, Salvatore (9)
Carlander, Oswald R. (4)
Carleton, Charles K. (14)
Carlisle, J. Mallory (20)
Carlisle, John H. (16)
Carlisle, Paul E. (7)
Carlough, David J. (16)
Carlucci, Angelo M. (18)
Carmona, L. Roberto (15)
Carpenter, Cedric C. (20)
Carpenter, Charles A. (7)
Carr, Alexander M. (12)
Carr, Josephus C. (7)
Carr, Mary B. (9)
Carrigan, Francis P. (7)
Carrol, Wilfred (7)
Carroll, C. Walter (11)
Carroll, Thomas R. (2)
Carroll, William V. (11)
Carsley, Sidney H. (20)
Carter, Joseph F. S. (13)
Cartisser, Joseph J. (19)
Cartnick, Louis C. (2)
Caruso, Paul F. (2)
Casagrande, Stephen R. (13)
Casale, John B. (7)
Casciano, Adolph D. (9)
Case, Clarence E., Jr. (18)
Casey, Robert B. (20)
Casilli, Arturo R. (20)
Castaldo, Neil (20)
Castellano, Martin G. (7)
Catania, Joseph P. (2)
Catanzaro, Francesco (16)
Catapano, John (2)
Catlaw, J. Kenneth (9)
Cavalli, Ralph D. (4)
Cella, Charles F. (11)
Cerone, Daniel M. (7)
Cestone, Canio (7)
Cetrulo, Gerald I. (7)
Chaiken, Louis H. (20)
Chalfant, W. Paxson, Jr. (1)
Chalfant, William P. (8)
Chamberlain, Richard R. (7)
Chapman, Ellis J. (9)
Chapman, Otis P. (20)
Chapman, Walter I. (16)
Chapnick, Maurice M. (16)
Charleroy, Durant K. (11)
Charlton, C. Coulter (1)
Charney, William (16)
Chase, Anthony V. (18)
Chase, Kalman, Jr. (2)
Chattin, J. Franklin (7)
Chayes, Sydney (9)
Cherashore, Harry N. (7)
Chernus, Jack (7)
Cherry, Homer H. (16)
Cheskin, Louis J. (7)
Chesler, Maurice (17)
Chesner, William A. (11)
Chesnick, Reuben B. (4)
Chester, Saul W. (16)
Chianese, C. Chester (11)
Chiaramida, Joseph (7)
Chieffo, Henry (9)
Childers, Robert J. (20)
Chilton, Forrest S. (16)
Chimacoff, Hyman (7)
Chmelnik, Abraham G. (7)
Chodosh, Maurice A. (20)
Chrisman, Irving (16)
Christensen, Alexander H. (10)
Christensen, Osborne D. (2)
Christian, Henry A. (9)
Christoph, Francis T. (7)
Chudzik, Edward W. (16)
Churg, Jacob (16)
Ciampa, Ralph P. E. (13)
Ciccone, Anthony C. (16)
Ciccone, Edwin L. (7)
Cicione, Edward (3)
Cieri, Daniel S. (9)
Ciliberti, Frank J., Jr. (4)
Cioffi, Eugene (21)
Citrino, Robert J. (7)
Clarle, D'Arcy C. (2)
Clark, Alice L. (11)
Clark, Ernest W. (4)
Clark, Frank G. (10)
Clark, John C. (13)
Clark, Margaret A. (2)
Clark, Morris B. (4)
Clark, Orlo H. (16)
Clark, S. Worth (1)
Clarke, Francis M. (12)
Clarken, Joseph A. (7)
Cleary, Joseph P. (1)
Clement, Baxter L. (7)
Clement, John B. (11)
Close, Byron H. (16)
Cloud, Albert W. (2)
Clunan, Ambrose P. (11)
Coburn, J. Wesley (7)
Coe, Edward M. (20)
Coffin, Henry F. (7)
Cogan, Henry (16)
Cohan, Charles C. (11)
Cohan, Joseph (11)
Cohen, Harry X. (20)
Cohen, Herman (9)
Cohen, Herman (11)
Cohen, I. Elvin (7)
Cohen, Julian (16)
Cohen, Louis (16)
Cohen, M. Marvin (16)
Cohen, Maurice (7)
Cohen, Maurice B. (5)
Cohen, Max (7)
Cohen, Oscar H. (14)
Cohen, Paul (4)
Cohen, Samuel (9)
Cohen, Samuel A. (9)
Cohen, Sidney L. (7)
Cohen, Sidney P. (7)
Cohen, William (11)
Cohn, George M. (7)
Cohn, Hermann (7)
Cohn, Isidor (16)
Cohn, Royal M. (7)
Colavita, James J. (11)
Colby, Maxwell X. (13)
Cole, L. Frank (16)
Cole, Nathaniel B. (12)
Cole, Walter H., Jr. (20)
Coleman, Austin H. (10)
Coleman, Joseph G. (19)
Coleman, Russell M. (7)
Collier, Martin H. (4)
Collins, Laurence M. (14)
Collins, Louis K. (8)
Colmer, M. Jonas (7)
Colsh, LeRoy L. (7)
Colton, Ethan T., Jr. (7)
Comando, Harry N. (7)
Comeau, George W. (14)
Comfort, John B. (11)
Commini, Frank F. (11)
Comora, Herman C. (9)
Comunale, Anthony R. (20)
Conlen, Richard (4)
Conlon, Philip J. (7)
Connamacher, Harold S. (7)
Connell, Emmet J. (9)
Connell, James (4)
Connolly, John J. (7)
Connolly, Joseph P. (16)
Connolly, Richard N. (7)
Connolly, Thomas W. (9)
Connor, Clarence A. (2)
Conroy, John S. (3)
Conserva, Peter V. (16)
Conte, Andrew N. (11)
Conti, Horace (7)
Conty, Anthony J. (9)
Conway, James V. (20)
Cook, Caroline S. (18)
Cook, Dora G. (14)
Cook, Homer E. (18)
Cook, Hugh F. (7)
Cooper, David P. (7)
Cooper, Howard M. (2)
Cooper, Irving J. (12)
Cooper, Jules (5)
Cooper, Robert A. (4)
Cooperman, Eli L. (12)
Cooperman, William (7)
Copleman, Benjamin (12)
Copleman, Hyman B. (12)
Coplin, George J. (20)
Coppoletta, Joseph M. (2)
Corbusier, Harold D. (20)
Corio, George A. (11)
Corless, Joseph F. (9)
Corn, David (2)
Cornish, Charles H. (7)
Cornwell, Robert A. (5)
Corrigan, Patrick H. (11)
Corson, Filbert R. (1)
Corson, Kenneth E. (6)
Cortese, Alvin E. (16)
Corwin, Emanuel M. (14)
Cosgrove, Robert A. (9)

Cosgrove, Samuel A. (9)
Costa, George J. (9)
Costa, Philip L. (13)
Costabile, Vincent (2)
Costello, William F. (14)
Cott, A. Allan (7)
Cotton, Henry A., Jr. (11)
Cotton, Norman T. (16)
Cottone, R. John (11)
Cottrell, Judson G. (12)
Coughlan, Ella A. (7)
Coughlin, Frank J. (7)
Coultas, Aldo B. (14)
Covino, Louis L. (7)
Cowlbeck, H. Donald (11)
Cox, Harold C. (11)
Cox, J. Robert (17)
Cox, John C. (7)
Cox, William T. R. (20)
Cox, William W. (7)
Coxson, Harold P. (4)
Crabtree, Loren H. (20)
Cracco, Frederick A. (9)
Craig, Henry A. (18)
Crandall, John K. (2)
Crandell, C. Archie (14)
Crane, Bernard (1)
Crane, Charles G. (7)
Crane, Norman T. (20)
Crapanzano, Domenico (7)
Craster, Charles V. (7)
Crawford, Georgina U. (7)
Crecca, Anthony D. (7)
Crecca, William D. (7)
Cregar, John S. (7)
Cremens, John F. (16)
Crescente, Fred J. (16)
Cricco, Carl F. (9)
Crist, Walter A. (4)
Cronin, Francis J. (20)
Cropsey, Charles D. (2)
Crossfield, Henry C. (7)
Crounse, David R. (16)
Crowe, Aldrich C. (5)
Crowley, Joseph W. (4)
Cryder, Millard C. (5)
Crystell, Edward H. (7)
Ctibor, Vladimir F. (10)
Cucinella, Anthony B. (7)
Cufari, Carmine J. (9)
Cummins, Ella F. (14)
Cunningham, Charles, Jr. (6)
Cunningham, Joel B. (4)
Cupaiuoli, Richard A. (9)
Curry, Marcus A. (14)
Curtis, A. Maurice (16)
Curtis, Donald A. (2)
Curtis, Elbert A. (7)
Curtis, Howard C. (3)
Cutler, Milton (1)
Cziraky, Anton (9)

ASSOCIATE MEMBERS

Cacchioli, Louis G. (7)
Campbell, Charles P. (2)
Carusi, Leonard G. (16)
Cassio, William L. (7)
Chandler, Swithin, Jr. (11)
Chromow, Bernard (7)
Church, Charles F. (12)
Ciccone, Roy (16)
Cichon, Elmer J. (16)
Cincotti, Victor F. (7)
Comando, Edward N. (7)
Cooper, Jehu P. (7)
Cowen, Mortimer I. (12)
Crane, Warren E. (11)
Crater, Kenneth E. (7)
Crecca, Joseph V. (7)
Crilly, James A. (13)
Culver, Perry (7)

D

ACTIVE MEMBERS

D'Acierno, Pellegrino A. (9)
D'Addario, Anthony R. (7)
D'Agostin, Henry (2)
D'Agostini, Alfred J. (7)
D'Agostini, Robert J. (7)
Dailey, Edward S. (7)
Dalley, Jeremiah (14)
D'Alessandro, Arthur J. (7)
Dalton, S. Eugene (1)
Daly, Edmund J. (9)
Daly, John F. (2)
D'Amato, Charles R. (2)
D'Ambola, Philip R. (7)
D'Amico, Thomas V. (7)
Dandois, George F. (5)
Dane, Charles (7)
Dane, John (7)
D'Angelo, Joseph C. (7)
Danielson, John J. (9)
Dann, Frederick J. (7)
Dante, Pasquale (7)
Dantzig, Henry (10)
Danzis, Louis (7)
Danzls, Maximillian (7)
Darby, I. Kermit (7)
D'Arcy, Walter E. (11)
Darden, Walter T. (7)
Darlington, Emlen P. (3)
Daron, Simeon (7)
Dasher, William A. (9)
Davenport, Irwin P. (11)
Daversa, Benjamin (13)
Davidson, E. Norwell (20)
Davidson, Eric W. (7)
Davidson, Harold S. (1)
Davidson, Henry A. (7)
Davidson, Maurice M. (7)
Davies, George A. (6)
Davies, George W. (7)
Davis, A. Hobson (16)
Davis, Albert B. (4)
Davis, Daniel (9)
Davis, E. Vernon (3)
Davis, F. Cleveland (20)
Davis, Harold (2)
Davis, J. Stannard (4)
Davis, Harold L. (11)
Davis, Jacob M. (3)
Davis, John E., Jr. (11)
Davis, Louis (7)
Davis, Stanton H. (20)
Davis, Thomas C. (7)
Davison, C. Spencer (17)
Davison, Royden W. (11)
Davison, Wilbur S. (17)
Dawson, Harry (16)
Day, Samuel T. (6)
Day, Willis B. (20)
Dayton, Spencer T. (2)
Dean, Guy K., Jr. (11)
Dear, Abraham L. (7)
DeBell, Peter J. (16)
DeBiaso, Cornelius V. (2)
DeCecio, Thomas (2)
DeCesare, Ferdinand J. (20)
Decker, Charles T. (20)
Decker, Frederick H. (10)
Decker, Henry B. (4)
Deehl, Seymour R. (20)
DeFelice, Mario T. (14)
DeFilippis, Ralph L. (7)
DeFronzo, Morando (7)
DeFusco, G. Thomas (9)
Degenhardt, Ira H. (12)
DeGerome, James H. (7)
DeGrace, Francis H. (16)
DeGregorio, Peter J. (14)
DeHart, George K. (7)
deHellebranth, Roland T. (1)
Deibert, Irvin E. (4)
Deibert, Kirk R. (4)
Deich, Samuel R. (16)
Deichman, Charles H. (14)
Deignan, William L. (7)
Deln, Harry (1)
Deitmaring, Francis A. (9)
Deitz, Joseph R. (11)
Delaney, Oscar M. (7)
Delario, Anthony J. (16)
Delcau, Jules (13)
Del Deo, Nicholas V. (7)
Del Duca, Vincent P. (4)
DeLeonardis, James V. (7)
Del Guercio, Olindo (7)
DeLia, Emilio (7)
D'Elia, William J. (13)
Della Fera, Lucien F. (7)
Della Penna, Samuel J. (16)
Della Ragione, Mario (7)
Del Mauro, Alphonse (16)
Del Negro, Albert E. (7)
DeMarco, Silverino V. (9)
Demaree, Richard H. (13)
Demarest, Gerald B. (20)
Demarest, J. Willis (2)
DeMattia, Michael (16)
DeMichele, Roland V. (7)
Dempsey, J. Harvey (4)

Denbo, Elic A. (4)
Denelsbeck, J. Otis (11)
Denes, Oscar (7)
Dengler, Henry P. (20)
Dengrove, Edward (13)
Denholtz, Emanuel (7)
Denison, Ward C. (16)
Dennison, Alfred D., Jr. (7)
DePalma, Anthony F. (7)
DePhillips, Benedict R. (7)
DePietro, Vincent P. (8)
dePons, Sarah C. (13)
DeRosa, Armand (16)
DeRosa, Louis (9)
Dershewitz, Irving (9)
DeSantis, Orazio J. (6)
DeSanto, Anthony M. (2)
DeSevo, Gerard E. (9)
Desmet, Victor F. (16)
Detrano, Salvatore J. (9)
DeTroia, Frederick C. (7)
Deuell, William D. (2)
Deutel, Oscar R. (7)
Deutsch, Nathan S. (20)
DeVincentis, Henry (7)
DeVincenzo, F. Richard (9)
DeVita, Anthony J. (13)
Devlin, Arthur D. (7)
Devlin, Hugh J. (7)
Dexter, Harriet E. T. (9)
DeYoe, Leon E. (16)
Dezer, Charles N., Jr. (2)
Diamond, David I. (13)
Diamond, J. George (20)
Dias, Joseph L. (7)
Dickson, John D. (2)
Dickson, T. Bruce (3)
Dieffenbach, Richard H. (7)
Dieker, Howard E. (12)
Diener, Samuel (7)
DiFino, Felix J. (7)
DiGiacomo, Harry E. (7)
DiGiacomo, William H. (7)
DiGiola, John (9)
DiIelsi, Anthony J. (4)
Dilger, Frederick G. (2)
DiMarino, Anthony J. (8)
Dimitrow, Helen (13)
D'Imperio, Francesco (4)
Dimun, John T. (11)
Dinge, Ferdinand C. (7)
Dingman, Norman M. (16)
DiNicolantonio, Vincent J. (1)
DiNorcia, Joseph (7)
Dirdack, Morris (14)
Dochtermann, Warren P. (14)
Dodd, William E. (15)
Dodge, James T. (11)
Doggett, E. Hugh (20)
Doherty, William (20)
Doktor, David (16)
Dolganos, Moses (9)
Dolsky, Irving (20)
Donahue, William J. (7)
Donchi, Sol M. (7)
Donges, Clarence B. (4)
Donnelly, John H. (7)
Donnelly, Joseph E. (16)
Donnelly, Joseph P. (9)
Donnelly, William A. (1)
Donohoe, Lucius F. (9)
Donohue, Daniel J. (9)
Donovan, Joseph (14)
Doody, William M. (9)
Doran, Ralph J. (9)
Doran, William G. (9)
Doranz, Harold K. (11)
Dorr, Henry B. (13)
Dorris, Earl D. (7)
Dougherty, Daniel D. (9)
Douglass, William C. (18)
Dow, Robert F. (16)
Dowds, Samuel C. (7)
Downing, Perley E. (12)
Downs, Louis S. (12)
Downs, Roscius I. (3)
Doyle, George F. (2)
Drake, Daniel E. (16)
Drake, Leo B. (19)
Drake, Paul F. (21)
Dranow, Paul (7)
Drapkin, Berta (7)
Dredge, Thomas J. (14)
Dren, George W. (16)
Dresel, Irmgard (18)
Dreskin, Jacob L. (7)
Drewniany, Bernardine (7)
Drezner, Henry L. (11)
Driscoll, Charles D. (4)
Drossner, Jacob L. (4)
DuBois, Morris G. (7)
duBusc, L. C. Victor (20)
Duckett, Warren J. (9)
Dudley, Henry G. (20)
Duffy, Edward P., Jr. (7)
Dukes, Howard R. (9)
Dulany, Theodore L. (7)
Dulin, Everett V. (7)
Duncan, Owsley B. (16)
Dunham, Malcolm M. (12)
Dunn, H. Irving (20)
Dunn, John S. (17)
Dunn, Theodore B. (7)
Dunning, Walter L. (16)
Dupuy, Jean G. (20)
Durchlag, E. Nelson (7)
Durham, Robert B. (1)
Durham, Royal E. (1)
Durrah, Fred F. (20)
Duschock, Edward F. (12)
Duvall, Albert I. (13)
Dwork, Harold K. (7)
Dwoyer, Leon C. (20)
Dwyer, Henry E. (16)
Dwyer, Willlam A. (16)
Dyer, Edward H. (1)

ASSOCIATE MEMBERS

Dallio, Salvatore V. (2)
Dana, Edward (2)
Dedick, Andrew P., Jr. (13)
DeDominicis, Frank A. (16)
Delafrange, Kenneth M. (2)
DeLorenzo, Francis (7)
DeLuca, Louis (2)
Dlerwechter, Reuben (1)
DeSimone, Louis E. (13)
Dmytriw, Stephen (7)
Dolan, Gerald J. (2)
Douglass, Frederick W. (7)
Drewery, Robert E. (7)
Drews, Francis F., Jr. (2)
Dreyfors, Madeline K. (13)
Duffy, Robert W. (2)
Dul, Emil J. (2)

E

ACTIVE MEMBERS

Eames, William N. (11)
Earp, Ruth (14)
Eason, Samuel W. (20)
East, Isaac C. (12)
Ebenfeld, Samuel W. (7)
Ebner, Paul G. (4)
Echikson, Joseph I. (7)
Eck, Daniel B. (7)
Eckert, Walter L. (1)
Eckhardt, Ralph A. (14)
Eddy, Lester R. (19)
Edelberg, Sidney S. (18)
Edelen, James J. (7)
Edelson, Edmond (7)
Edelson, Samuel (13)
Edelstein, Isidore (9)
Edgar, Malcolm S. (20)
Edgerly, Sherburn E. (2)
Edlkraut, Edward C. (16)
Edwards, J. Bennett (2)
Edwards, Lena F. (9)
Edwards, Walter R. (11)
Ehrenfeld, Edward (16)
Ehrenfeld, Irving (16)
Ehrlich, Edward (7)
Ehrlich, Max (20)
Ehrlich, William E. (7)
Ehrlich-Morrow, Laura E. (2)
Eichler, Bernard B. (7)
Eln, William B. (7)
Einhorn, Samuel E. (7)
Elsemann, Jerome S. (16)
Eisenberg, David S. (7)
Elsenhower, J. S. D. (5)
Eisenstodt, Lester W. (7)
Ekings, Frank P. (16)
Elias, Elmer J. (11)
Ellenson, Solomon S. (13)
Ellis, Alexander (4)
Ellis, Arthur J. (7)
Ellmers, Basil J. (2)
Elsasser, Theodore H. (9)
Elwell, Alfred M., Jr. (3)
Elwood, Benjamin J. (9)
Ely, Lancelot (18)

Emerson, Linn (7)
Emmer, S. Wolfe (7)
Emory, George B., Jr. (14)
Engelhart, Ferdinand K. (11)
Englander, Charles (7)
English, Harrison F., III (11)
English, John T. (7)
English, Samuel B. (10)
Enright, James G. (9)
Epstein, Harry B. (7)
Epstein, William M. (7)
Erber, Leonard B. (1)
Erdman, George L. (7)
Erler, Robert E. (7)
Ernest, Richard B. (11)
Ernst, Philip A. (1)
Ervin, Millard B. (7)
Esposito, Amedeo C. (14)
Esposito, Anthony L. (16)
Esposito, Antonio L. (1)
Essertier, Edward P. (2)
Essertier, Harland C. (2)
Esty, Geoffrey W. (20)
Etheridge, Charles H. (7)
Ettinger, Samuel (9)
Eulner, Elmer H. (12)
Evans, Charles H. (7)
Evans, David P. (7)
Evans, Edgar E. (17)
Evans, Edgar J. (14)
Evans, J. Lawrence (9)
Evans, J. Lawrence, Jr. (2)
Evans, Joseph O. (20)
Ewens, Arthur E. (1)
Ewing, Harvey M. (7)
Ewing, Leslie H. (4)
Eynon, Harold K. (4)
Eynon, James R. (4)

ASSOCIATE MEMBERS

Eckhardt, Janet L. (7)
Eckstein, David (11)
Edson, James (16)
Edwards, Sydney K. (7)
Evans, John R., Jr. (7)

F

ACTIVE MEMBERS

Faber, Edward (9)
Fabian, Paul L. (11)
Fabriele, John B. (9)
Facciolo, Frank (9)
Fadden, Francis J., Jr. (2)
Fader, Ferdinand (7)
Fagan, James L. (12)
Fager, Rudolph O. (7)
Fahrenbruch, Frederick D. (3)
Failing, Brayton E. (7)
Failmezger, Theodore R. (14)
Faison, John B. (9)
Falconer-Slater, Katherine (20)
Falvello, Nicholas A. (14)
Fanburg, Sol J. (7)
Fanelli, Antonio (12)
Farb, Harry H. (7)
Farkas, Gustav (16)
Farkas, Morris (7)
Farmer, Vincent (2)
Farmer, Walter D. (11)
Farr, Walter J. (2)
Farrell, Edgar A. H. (4)
Fasano, Giovanni (7)
Fath, Marcus A. (5)
Fattel, Henry C. (9)
Faughnan, Rose C. (7)
Faulkingham, Ralph J. (12)
Fauquier, Leonard B. (9)
Faux, Frederick J. (8)
Fava, Philip V. (7)
Fazio, Vincent J. (13)
Fechner, Julius (7)
Federer, John J. (9)
Feher, Ladislas A. M. (12)
Feigenoff, Israel (16)
Fein, Bernard (7)
Feinberg, Harry (9)
Feinberg, Harry D. (13)
Feinsod, Samuel N. (7)
Feinstein, Louis (1)
Felder, Samuel (10)
Feldman, Frank H. (7)
Feldman, Joel (13)
Feldman, Morris (9)
Feleppa, Edward E. (20)
Feliciano, Vincent (16)
Feller, William (9)
Feman, J. George (13)
Fendrick, Edward (7)
Fenimore, Frank D. (14)
Fenster, Morton N. (16)
Fenton, Tennant E. (13)
Fenwick, John R. (16)
Ferenchak, Ralph (20)
Ferguson, John (13)
Ferguson, William E. (7)
Fermaglich, Harry B. (2)
Fern, Samuel S. (7)
Ferrari, Andrew F. (2)
Ferrary, Paul B. (16)
Ferriss, Ruth B. (14)
Fessler, A. James (11)
Fessman, John W. (4)
Feuer, Joseph A. (7)
Fialk, Harry (9)
Ficke, Sylvia A. (9)
Fiedler, Michael J. (20)
Field, Frank L. (18)
Fielding, William M. (16)
Fiering, Abraham M. (16)
Fietti, Vincent G. (2)
Fifer, William T. (9)
Figliolino, Francis (20)
Figurelli, Francis A. (9)
Filkins, Cedric E. (4)
Finby, Nathaniel (14)
Fine, Hyman P. (12)
Fine, Irvin J. (12)
Fine, Sydney G. (11)
Finegan, Paul J. (11)
Finger, Frederick A. (9)
Fink, A. Elston (7)
Fink, Irving E. (7)
Fink, Stanley J. (20)
Finke, Charles H. (9)
Finke, George W. (2)
Finke, John H. D. (2)
Finkel, Joshua (7)
Finkelstein, Abe S. (7)
Finkelstein, Max (9)
Finkle, Lester J. (11)
Finkler, Rita S. (7)
Finn, Frederick A. (9)
Finn, Henry R. W. (9)
Finnerty, Urban R. (7)
Fiorello, Joseph R. (11)
Fischbach, Adolph D. (3)
Fischbein, Martin M. (7)
Fischer, David D. (7)
Fischer, Edward J. (7)
Fischer, Leo E. (9)
Fischer, Louise (7)
Fischman, Harold H. (7)
Fishbein, Elliot (16)
Fisher, James A. (13)
Fisher, Samuel (16)
Fisher, Stella C. (4)
Fishkoff, Alexander H. (12)
Fisler, Charles F. (8)
Fitch, Thomas S. P., (20)
Fithian, George W. (12)
Fitzhugh, William F. (2)
Fitzpatrick, Leo J. (2)
Flanagan, James F. (7)
Flanagan, John J. (7)
Flax, Charles H. (7)
Flax, Ira I. (7)
Flax, Jacob L. (7)
Fleischmann, Viola G. (7)
Fleming, Charles L. (17)
Fleming, Joseph A. (7)
Flichtenfeld, Morris (9)
Flicker, David J. (7)
Fliegel, Hilda C. (9)
Fliegel, William M. (2)
Flint, Edgar T. (18)
Flitcroft, William (16)
Floody, Robert J. (7)
Flower, Morrie A. (7)
Fluck, David A. (11)
Fluck, Paul H. (10)
Flynn, Edward A. (7)
Foley, James F. (7)
Fooder, Horace M. (8)
Foote, Sherman K. (16)
Forbes, John S., Jr. (14)
Ford, Theodore R. (7)
Forer, Robert (11)
Forney, Norman N. (12)
Forney, Norman N., Jr. (12)
Forrest, Henry (12)
Forsberg, Roy T. (20)
Fort, J. Irving (7)

Fort, William B. (20)
Fortay, Steven O. (16)
Forte, Daniel L. (7)
Forte, F. Chester (2)
Forte, Frank S. (7)
Fortuln, Floyd (16)
Fortunato, Samuel J. (7)
Fost, William H. (7)
Foster, Frank L. (20)
Foster, Herbert W. (7)
Fowler, Richard M., Jr. (1)
Fowler, Royale H. (7)
Fox, William W. (1)
Frame, Dorothy L. (7)
Francy, Donald G. (7)
Frank, Geza M. (7)
Frank, Herman I. (9)
Frank, Morris (9)
Frank, Myrtile (1)
Frank, Nathan (9)
Frank, Perry (1)
Frank, Simon C. (7)
Franklin, Charles M. (11)
Franklin, Frank A. (7)
Franklin, I. Harold (9)
Franklin, Joseph E. (20)
Franklin, Lewis J. (20)
Franklln, Sldney I. (2)
Frantz, Max K. (4)
Franzoni, Andrew E. (11)
Fratantuno, Michael J. (7)
Fraulo, Louis (16)
Freedman, Harold H. (13)
Freedman, Jacob S. (16)
Freeland, Frank (2)
Freeman, George C. (7)
Freeman, Ray M. (20)
Freeman, Richard D. (7)
Freinkel, Jacob (7)
Freyberger, George A. (9)
Freymann, Walter (9)
Fridrich, Harry E. (4)
Friedburg, George H. (20)
Friedenberg, Sidney (4)
Friedenthal, Bernard (12)
Friedland, Arnold J. (6)
Friedlander, Kurt F. (7)
Friedman, Abraham I. (2)
Friedman, Edna C. (16)
Friedman, Harry (7)
Friedman, Hyman (7)
Friedman, Max (11)
Friedman, Meyer H. (11)
Friedmann, Leonard L. (11)
Frieman, Hyman (9)
Fritsch, Alfred (7)
Fritts, Lewis C. (18)
Fritz, John F., Jr. (10)
Froelich, Joseph C. (7)
Frohwein, Ida H. (20)
Fromkin, Charles (6)
Frost, Inglis F. (14)
Fruchtbaum, Robert P. (7)
Fuchs, Jacob N. (11)
Fuhrmann, Barclay S. (10)
Fuhrmann, John B. (10)
Furman, Benjamin A. (7)
Furst, Nathan J. (7)
Furst, William (7)

ASSOCIATE MEMBERS

Fain, Irving (7)
Ferrari, Salvatore (16)
Finkelstein, Aaron (7)
Finnegan, William R. (12)
Flschman, Mervin (7)
Freeman, Willlam S. (12)
Friedmann, Gustav (16)
Friery, John F. (2)
Frisch, Felix (11)

G

Gadek, Stanley A. (12)
Gadek, William V. (12)
Gadomski, Casimir F. (20)
Galeota, William (10)
Galgoczy, Julius (18)
Galioto, Frank M. (7)
Gallardo, Agustln (16)
Gallaway, George E. (20)
Gallo, James S. (16)
Gamba, Joseph (7)
Gambacorta, Leopoldo (7)
Gambill, Perry J. (14)
Gamon, Robert S. (4)
Gamsu, George (7)
Ganley, Arthur J. (7)
Gannon, Joseph M. (20)
Ganot, Frank I. (7)
Gantt, Margaret H. (14)
Garbarini, John G. (9)
Garber, Robert S. (11)
Gardam, Joseph W. (7)
Gardner, Kenneth E. (7)
Garibaldi, Louis J. (9)
Garnett, Robert (16)
Garrison, W. Sherman (6)
Gartian, Bernard W. (15)
Garwood, Norman W. (11)
Gatti, Joseph D. (2)
Gaylor, Earl L., Jr. (7)
Geannette, Ernest D. (7)
Geary, Daniel J. (14)
Geary, Paul (20)
Geary, Russell D. (3)
Gebele, Wlilam X., Jr. (15)
Gebirtig, Theodore (14)
Gehl, Raymond H. (7)
Gehl, Sidney H. (7)
Geib, Margaret E. (20)
Geiger, Harold C. (16)
Geissler, Elmer E. (4)
Geib, Jerome (7)
Gellman, William B. (16)
Gelman, Sidney (16)
Gennell, Ernest (7)
Gentile, Ernest R. (18)
George, Amerlgo (13)
George, Melbourne E. W. (7)
Gerard, Arpad G. (12)
Gerard, Patrick D. (7)
Gerendasy, Julius (20)
Gerhardt, Paul E. (7)
Germain, Raymond J. (10)
German, George B. (4)
Gerne, Timothy A. (9)
Gerner, Harry E. (9)
Gershenfeld, David B. (7)
Gershman, Joseph G. (2)
Gessner, Gerard R. (12)
Gesswein, Carl A. (13)
Ghee, Euclid P. (9)
Giacona, Joseph (20)
Giambra, Sante M. (16)
Giannasio, Joseph (9)
Gianni, Angelo R. (14)
Giardina, John S. (7)
Giardina, Vincent J. (7)
Gibb, Alice S. (20)
Glbbins, A. Leslie (7)
Gibson, Augustus (7)
Gibson, Charles F. (3)
Giffoniello, Arthur A. (7)
Gifford, William R. (7)
Giglio, Alphonsus S. V. (20)
Gigllo, Louis A. (16)
Gilady, Raphael (2)
Gilbert, Philip D. (4)
Gilbert, Samuel M. (7)
Gilbertson, Robert L. (14)
Gilman, Charles M. B. (7)
Gilmour, John R. (7)
Gilpin, Fletcher (20)
Ginhart, Floyd D. (11)
Glndhart, John H. (11)
Ginsberg, George (9)
Ginsberg, Leon (7)
Ginsburg, Samuel (16)
Glordano, Salvatore (14)
Giordano, Willlam C. (2)
Girardo, Anthony J. (4)
Gittelman, Morton (20)
Gittelsohn, Isador (2)
Gitterman, David A. (2)
Giuffra, Frank (7)
Giuliana, Robert A. (7)
Gladstone, Albert L. (2)
Glaser, Emanuel (20)
Glasgow, Thomas M. (16)
Glass, Benjamln E. (20)
Glass, George A. (18)
Glass, Harry L. (20)
Glass, Oscar (7)
Glass, William H. (7)
Glasser, Benjamln F. (12)
Glassner, Frank (20)
Glasston, Hyman M. (20)
Glazebrook, Francis H. (14)
Glazer, Edward (13)
Glazier, Jesse T. (7)
Gleeson, Willlam J. (9)
Glick, Bernard (2)
Glover, Lawrence L. (4)
Gluckman, I. Edward (7)
Gluckman, Saul K. (7)
Glynn, S. Robert (7)
Gobel, Stanley J. (12)
Gnassi, Angelo M. (9)
Gochman, Harry M. (16)

Godfrey, Alan O. (7)
Goehring, Harrison D. (7)
Goeller, Jacob D. (7)
Goffman, Emanuel (7)
Goldberg, Benjamin M. (11)
Goldberg, Bernard R. (7)
Goldberg, David (2)
Goldberg, Harold H. (7)
Goldberg, Harry C. (12)
Goldberg, Isidore (12)
Goldberg, Jacob (13)
Goldberg, Louis E. (7)
Goldberg, Samuel A. (7)
Golden, Clement H. (7)
Golden, William M. (20)
Goldenberg, Raphael R. (16)
Goldfarb, Abraham (2)
Goldfield, Harold H. (20)
Golding, Harry N. (16)
Golish, Harry L. (16)
Goldmacher, Herman B. (20)
Goldman, David L. (9)
Goldman, Jerome (7)
Goldman, Leo L. (11)
Goldman, Lester M. (7)
Goldman, Samuel (4)
Goldman, Sol B. (16)
Goldman, Solomon (12)
Goldmann, Joseph (7)
Goldowsky, Ira (9)
Goldsmith, Alfred S. (9)
Goldstein, Abraham (15)
Goldstein, Edward W. (16)
Goldstein, Henry Z. (7)
Goldstein, Herman H. (20)
Goldstein, Hyman I. (4)
Goldstein, Samuel (1)
Goldstein, Samuel M. (7)
Gonczy, Edward J. (20)
Good, Richard (9)
Goodman, Kenneth (7)
Goodrich, Stewart L. (9)
Gordon, A. Julius (7)
Gordon, Abel (16)
Gordon, Benjamin L. (1)
Gordon, Charles D. (14)
Gordon, Frank S. (21)
Gordon, Isaac L. (9)
Gordon, J. Berkeley (13)
Gordon, Maurice B. (1)
Gordon, Milton H. (4)
Gordon, Norman W. (20)
Gordon, Samuel (16)
Gordon, William (16)
Gormley, Cyrus M. (16)
Gorog, Nicholas M. (12)
Gorson, Samuel F. (1)
Gorten, Manfred L. (7)
Gosper, Ralph W. (4)
Gottlieb, Morris (1)
Gould, John H. (16)
Gould, Werner (2)
Goyne, James B. (11)
Graber, Irving (13)
Graddick, Lester W. (14)
Graeter, F. Albert (16)
Graham, Archibald F. (16)
Graham, Ernest E. (11)
Graham, Theodore K. (16)
Granelli, Humbert A. (9)
Granger, James R. (11)
Grant, Francis (7)
Grant, Raymond J. (14)
Grant, William E. (20)
Grant, William F. (7)
Grasso, Anthony P. (7)
Graves, Charles C., Jr. (13)
Gray, Charles M. (6)
Gray, John W. (7)
Gray, W. Burritt (18)
Greca, Lionel A. (20)
Green, David W. (17)
Green, Thomas J. (15)
Greenberg, George A. (18)
Greenberg, Jacob L. (7)
Greenberg, Max (20)
Greenberg, Philip (9)
Greenberg, Samuel (7)
Greene, Albert D. (9)
Greene, Edwin C. (6)
Greenfield, Arthur W. (2)
Greenfield, Bernard H. (7)
Greenfield, Herbert (7)
Greenfield, Leonard S. (7)
Greenfield, William J. (2)
Greengrass, Jacob J. (16)
Greenwald, Eugene (7)
Greenwald, Theodore L. (7)
Greenwell, Albert W. (16)
Greenwood, Samuel B. (7)
Greenwood, William R. (12)
Greer, Melvin A. (7)
Gregory, Marie F. (14)
Gregory, Mildred G. (7)
Greifinger, Marcus H. (7)
Greifinger, William (7)
Grenhart, George W. (4)
Gribbin, James A. (11)
Gricco, Anthony L. (6)
Grieco, Emil H. (9)
Grier, Robert M. (1)
Griesemer, Z. Lawrence (20)
Griffey, William C. (4)
Griffin, Guy B. (7)
Griffith, Roy (7)
Grimes, Robert R. (2)
Griscom, I. Norwood (14)
Griscom, Lee E. (4)
Griswold, Merton L., Jr. (20)
Groff, Parker A. (2)
Gross, Irving (7)
Gross, Max (1)
Gross, Robert J. (2)
Grossbard, Paul (16)
Grossblatt, Philip (7)
Grossman, Rubin (9)
Grossman, Walter (12)
Gruber, William L. (7)
Grubin, Harold (7)
Grubowski, Joseph N. (9)
Grueninger, Edward F. (2)
Gruhler, Jean A. (1)
Grundorfer, Joseph (7)
Grunt, Louis (7)
Guarraia, Joseph (16)
Guglielmelli, Angelo D. (11)
Guidi, Guido M. (20)
Guidice, Vincent W. (2)
Guion, Edward (1)
Gulick, James B. (7)
Gullord, Edward G. (7)
Gurland, Benjamin B. (9)
Gurley, Katharine A. (9)
Gurnee, Quinby D. (16)
Gurshman, Sol. D. (12)
Gutmann, Erwin K. (9)
Gutowski, Joseph M. (12)
Gutowski, Walter T. (7)

ASSOCIATE MEMBERS

Gambacorta, Otto (7)
Gardiner, Muriel M. (11)
Garrett, Thomas A. (2)
Garzieri, Anthony (16)
Gaydos, Albert (7)
Gear, Phillip E. (7)
Ged, Archie K. (16)
German, Bernard (7)
Gian-Grasso, Joseph A. (11)
Giannotto, Anthony S. (7)
Gianquinto, Peter (7)
Goldstein, Benjamin (13)
Goldstein, Daniel L. (2)
Goodman, Stanley J. (7)
Gould, Louis F. (12)
Gras, Alfred E. (7)
Grant, Russell B. (2)
Green, Martin (1)
Greenfield, Sylvan J. (7)
Grubin, Charles J. (7)
Guito, Frank (13)
Gurian, Sydney H. (7)

H

ACTIVE MEMBERS

Hackett, Daniel C. (20)
Hadley, C. Frazer (4)
Hadley, C. Frazer, Jr. (4)
Hafetz, M. Morris (11)
Haggerty, D. Leo (11)
Haggerty, Francis F. (9)
Hagovsky, Albert J. (2)
Hahn, Katherine B. (7)
Hahn, William H. (7)
Haight, Harry W. (12)
Haines, F. B. Lane (5)
Haines, Keith E. (4)
Haines, Mabel C. S. (4)
Haines, Willits P. (5)
Halbeisen, William A. (4)

Halbstein, Bernard M. (13)
Haldeman, Robert E. (3)
Hale, Matthew J. (3)
Haley, Paul W. (7)
Hall, Ralph A. (20)
Hall, Wayne W. (16)
Hall, Winthrop H. (20)
Haller, Olga (7)
Halligan, Earl J. (9)
Hallinger, Earl S. (4)
Hallock, Wilton J. (20)
Halnan, John J., Jr. (16)
Halperin, David (9)
Halpern, Herman (2)
Halpern, Jesse O. (2)
Halpern, Melvin M. (7)
Halpern, Samuel (1)
Halpern, Sophia L. (9)
Halprin, Harry (7)
Halsey, Levi W. (7)
Hambright, Arthur M. (16)
Hamilton, Lloyd A. (10)
Hamilton, Robert G. (7)
Hamley, John J. (20)
Hammell, Frank M. (11)
Hammett, Lee J. (4)
Hampton, George R. (14)
Hanan, James T. (7)
Hancock, Michael Q. (13)
Hand, Frederick G. (7)
Handler, Harry (9)
Haney, John J. (11)
Hanrahan, James (20)
Hansen, Harold T. (7)
Hansen, Harry (20)
Hanson, Alfred S. (4)
Hanson, Carl G. (20)
Hantman, Harold (7)
Harbeson, James P., III (4)
Harden, Albert S. (7)
Harden, Albert S., Jr. (7)
Hardy, Grace C. (2)
Hardy, John W. (13)
Harley, Halvor L. (1)
Harman, J. Reginald (11)
Harman, William J. (11)
Harps, James A. (10)
Harreys, Charles W. (16)
Harrington, J. Henry (14)
Harris, Maurice N. (6)
Harris, Morris (7)
Harris, Sidney (20)
Harris, William O. (1)
Harryman, William K. (2)
Harter, Louis F. (9)
Hartman, Luther M. (3)
Hartman, Winfield L., Jr. (7)
Hartmann, Edmund M. (18)
Hartwell, H. Ameroy (9)
Harvey, John W. (9)
Harvey, Robert K. (7)
Harvey, Thomas W. (7)
Harz, William V. (9)
Hasking, Arthur P. (9)
Hatch, Harold S. (14)
Hatem, Elias J. (16)
Hauber, Eugene A. (12)
Hauck, Lydia R. B. (7)
Hauck, William H. (7)
Hauptman, Harry (9)
Haury, Victor G. (4)
Hausman, Samuel W. (13)
Haven, Samuel C. (14)
Hawes, Vernon L. (2)
Hawkes, E. Zeh (7)
Hawkes, Stuart Z. (7)
Hawkins, W. (18)
Hayden, Walter G. (15)
Hayes, Gerald W. (7)
Hayman, Irving R. (16)
Hays, Roy G. (4)
Haywood, Henry (12)
Heatley, William (13)
Hebble, Howard M. (3)
Hegeman, Runkle F. (18)
Heilbrunn, Julius (9)
Heineken, Theodore S. (7)
Helff, Joseph R. (2)
Heller, Abraham R. (7)
Heller, George (2)
Heller, Nathan B. (7)
Hely, Charles J. Jr. (20)
Heminway, Norman L. (20)
Hemphill, Everett H. (4)
Hendlich, Milton G. (7)
Henle, Carye-Belle (7)
Hennig, Paul F. (7)
Henriksen, J. Bruce (15)
Henry, Frank C., Jr. (12)
Henry, George (10)
Henry, Norman (6)
Hensle, Otto S. (2)
Herbener, Eugene G. (15)
Hermann, John H. (7)
Hernandez, Manuel (9)
Herndon, Lewis S. (7)
Herold, Harvey T. (7)
Herradora, Juan R. (9)
Herrington, Lee R. (20)
Herrman, William G. (13)
Hersh, David H. (7)
Hershey, Harry H. (9)
Hersohn, William W. (1)
Hertzberg, Irving (7)
Hess, George A. (11)
Hess, L. Elmore (1)
Hesseltine, Clair E. (12)
Hessert, Edmund C. (4)
Hewson, George F. (7)
Heyman, Arthur (7)
Heymann, Ernest F. (13)
Hicks, Alfred M. (7)
Hiden, Joseph C. (11)
Higgins, Gerald L. (9)
Higgins, John T. (9)
Higgins, Thomas A. (9)
Higi, Joseph E. (7)
Hiller, Stuart A. (14)
Hilker, George F. (12)
Hill, Dean F. (19)
Hill, Robert H. (7)
Hillel, Joseph (9)
Hilliard, William T. (17)
Hillman, Ernest C., Jr. (7)
Hillmann, Frederick C. (16)
Hillsman, R. Bryan (2)
Hilton, Clarence O. (7)
Hinckley, Livingston S. (7)
Hindle, F. Lawton (13)
Hinton, Samuel H. (12)
Hipple, Percy L. (20)
Hird, Emerson F. (18)
Hirsch, Allen H. (6)
Hirsch, Arthur (5)
Hirsch, John J. (2)
Hirsch, Lucien (20)
Hirsch, Samuel (16)
Hirsch, Theodore (7)
Hirschfield, Bernard A. (11)
Hirshorn, Arthur (4)
Hitzemann, Louis A. (2)
Hnat, Frederick (20)
Hobart, Richard T. (7)
Hoch, Samuel M. (20)
Hochheimer, Arthur (18)
Hodas, Sidney M. (13)
Hofbauer, Ernest (11)
Hofer, Clarence J. M. (12)
Hofer, William R. (4)
Hoffman, Charles A. (20)
Hoffman, Charles W. (12)
Hoffman, Florentine M. (12)
Hoffman, Harry (20)
Hoffman, Harry S. (1)
Hogan, Marshall D. (14)
Holderith, Albert E. (7)
Holland, Moses H. (9)
Holland, Reuben J. (20)
Holler, Henry G. (7)
Hollingsworth, H. Hale (16)
Hollinshed, Beulah S. (4)
Hollinshed, Ralph K. (8)
Holman, Francis W. (13)
Holmes, George J. (7)
Holmes, Grace A. (20)
Holmes, H. David (1)
Holmes, Thomas J. E. (16)
Holoman, M. Browne (1)
Holster, Stephen G. (16)
Holt, Evelyn (20)
Holt, Herman H. (16)
Holters, Otto R. (13)
Holtz, Harry M. (7)
Hooton, Thomas C. (7)
Hopping, John S. (14)
Hopping, Richard A. (7)
Horhovitz, George I. (11)
Horland, Aaron H. (7)
Horland, Ephraim (7)
Horn, Harry (7)
Horn, Max (7)
Hornberger, J. Howard (3)
Horner, John I. (4)
Hornick, Emil E. (14)
Hornstine, Harry H. (5)
Horoschak, Anne (20)
Horowitz, Alexander S. (9)
Horowitz, Herman J. (2)
Horowitz, Leo (9)
Horre, George W. H. (20)
Hosp, Paul H. (7)
Howard, J. Edgar (4)
Howard, James W. (7)
Howell, E. Gaylor (12)
Howell, Thomas W. (7)
Howeth, John L. (9)
Howley, Barth, Jr. (12)
Hubach, Maximilian F., Jr. (7)
Hubbard, Robert Y. (7)
Huber, William H. (7)
Huberman, John (7)
Hubert, Antonio O. (14)
Hughes, A. Joseph (4)
Hughes, Frank J. (4)
Hughes, Frank R. (5)
Hughes, Frederic J. (20)
Hughes, Harold F. (5)
Hughes, J. Vernon (16)
Hughes, James W., Jr. (1)
Hughes, Joseph F. (8)
Hughes, Lee W. (7)
Hughes, Samuel B. (5)

Hughes, Thomas E. (4)
Hulett, Albert G. (7)
Hull, Donald B. (2)
Humbert, Joseph C., Jr. (21)
Hummel, Ernest G. (4)
Hummel, Merwin L. (4)
Humphrey, Hubert G. (20)
Humphries, Robert E. (7)
Hunt, Melvin M. (12)
Hunt, Thomas F. (20)
Hunter, Edward R. (3)
Hunter, Floyd D. (11)
Hurff, J. Wallace (7)
Hurtado, Edward (20)
Huss, Louis (9)
Husted, Gerald W. (4)
Husted, Samuel H. (18)
Hutchinson, A. Dunbar (11)
Hutchinson, George F. (11)
Hutner, Cyril I. (12)
Hutton, Frederick T. (20)
Hyer, Godfrey S. (18)
Hyman, Charles (1)
Hymowitz, Ben (7)

ASSOCIATE MEMBERS

Hamburg, Meyer M. (12)
Hanfling, Seymour L. (7)
Harley, Robinson D. (1)
Harwood, Harry L. (2)
Hathaway, George, Jr. (16)
Haut, Edward M. (13)
Heisen, Aaron J. (13)
Hermann, John H., Jr. (7)
Hochman, Alex (16)
Holder, Lester (7)
Hummel, Frederick W. (13)
Hunziker, George P. (2)
Hyde, Robert T. (7)
Hyland, Michael (7)

I

ACTIVE MEMBERS

Ianacone, John A. (16)
Iatesta, Matthew (7)
Ill, Edmund W. (7)
Ill, Herbert M. (7)
Imbleau, Joseph E. L. (20)
Imhoff, John G. (9)
Imhoff, Robert E. (4)
Infield, Gerald L. (1)
Inge, Hutchins F. (7)
Introcaso, Dominick A. (9)
Iraggi, James V. (16)
Ironside, Paul A. (4)
Irvin, John S. (1)
Irving, Henry C. (9)
Irwin, Francis T. (7)
Irwin, James R. (7)
Irwin, John H. (2)
Isaac, Benoit C. (7)
Israeloff, Howard H. (7)
Ivey, Evelyn P. (14)
Ivins, William C. (11)
Ivory, Harry S. (15)
Izenberg, David (16)

ASSOCIATE MEMBERS

Iannone, Angelo B. (7)
Idelcowitz, Marie (12)
Insabella, John (7)
Isen, Paul J. (13)
Israel, Joseph (7)

J

ACTIVE MEMBERS

Jablonski, John J. (4)
Jack, H. Wesley (4)
Jackson, Charles H. (4)
Jackson, Elmer C. (21)
Jackson, George H. (7)
Jacobitti, Edmund E. (2)
Jacobs, Alan L. (20)
Jacobs, Benjamin (7)
Jacobs, William (7)
Jacobson, J. Joseph (1)
Jacobson, Murray B. (12)
Jaeckle, Charles E. (7)
Jaffe, Benjamin (9)
Jaffe, Herman M. (9)
Jaffe, Hyman (16)
Jaffin, Abraham E. (9)
Jahn, Albert G. (16)
Jaksch, Maria (9)
James, Bart M. (7)
James, J. Thomas (11)
Jamison, William F. (13)
Jani, Frank F. (16)
Janifer, Clarence S. (7)
Jaques, J. Eugenia (9)
Jarvis, Daniel G. (7)
Jaslow, Seymour P. (2)
Jaso, James V. (7)
Jaspan, Samuel C. (11)
Jedel, Meyer (7)
Jehl, Joseph R. (16)
Jenkins, Alvah R. (2)
Jenkins, Arthur M. (10)
Jenkins, R. Jewett (7)
Jennings, Robert E. (7)
Jentz, John H. (9)
Jessurun, Samuel H. (7)
Joelson, Dora (16)
Joelson, Morris S. (16)
Joffe, Philip M. (16)
Joffe, Sidney H. (16)
Johnsen, Sigurd W. (16)
Johnson, Archie W. (9)
Johnson, George F. (19)
Johnson, G. Leonard (2)
Johnson, Harold F. (20)
Johnson, Herbert F. (4)
Johnson, John F. (11)
Johnson, Robert A. (7)
Johnson, V. Earl (1)
Johnston, Julian F. (14)
Johnston, Sidney F. (2)
Jonas, August (17)
Jones, Clement M. (9)
Jones, Helen E. (13)
Jones, Herbert E. (20)
Jones, J. Morgan (9)
Jones, John C. (4)
Jones, Lewis H. (20)
Jones, William F. (18)
Jonitz, Robert (7)
Jordan, Alexander D. (13)
Jordan, Joseph C. (13)
Jordan, Walter L. (2)
Joseph, Benjamin M. (9)
Joseph, Morris (16)
Judd, Joseph, Jr. (20)
Judge, John F. (7)
Judson, G. Vernon, Jr. (4)
Judy, Kennеth H. (9)
Jukofsky, Isidore D. (2)
Just, Francis (7)
Justin, Arthur W. (9)

ASSOCIATE MEMBERS

Jacobson, Benjamin D. (12)
Johnson, Winton H. (2)
Judge, Thomas V., Jr. (7)

K

ACTIVE MEMBERS

Kachdorian, Vartan (11)
Kaderabek, Erwin J. (7)
Kahn, Leo (1)
Kahrs, Grace M. (7)
Kaighn, Charles B. (1)
Kain, Thomas M. (4)
Kain, Thomas M., Jr. (4)
Kainer, Herbert (9)
Kakascik, Emil J. (2)
Kalb, S. William (7)
Kaletkowski, Marlon F. (16)
Kallen, Arnold M. (7)
Kalter, George E. (7)
Kandra, Paul H. (20)
Kanengiser, Clifford H. (9)
Kaney, Emil M. (7)
Kaplan, Henry L. (7)
Kaplan, Herman B. (9)
Kaplan, S. Bernard (7)
Kaplan, Samuel D. (20)
Kapp, Carl G. (20)
Karel, Jack R. (20)
Karnay, Francis (20)
Karshmer, Ernest E. (20)
Karshmer, Nathan (12)
Kassow, Philip B. (21)
Kastler, Franz (2)
Katz, Harry (16)
Katz, Jacob D. (9)
Katz, Sidney (9)
Katz, Theodore (20)
Katzin, Eugene M. (7)
Kauder, Warren G. (7)
Kauffmann, Louis J. (6)
Kaufman, Jerome G. (7)
Kavanaugh, Daniel E. (7)
Kay, Albert E. (4)
Kay, Clarence R. (18)
Kazmann, Harold A. (13)
Kearney, Edward P. J. (7)
Kearney, John F. (7)
Kearney, Paul A. (7)
Keating, Charles A. (16)
Keating, Joseph M. (16)
Keats, Sidney (7)
Keegan, Thomas D. (9)
Keeney, Cadwell B. (20)
Keeney, James C. (9)
Keil, Sigmund S. (20)
Keim, William F., Jr. (7)
Keir, Floyd E. (2)
Keith, Theodore R. (7)
Kelemen, Nicholas M. (7)
Keller, Earl B., Jr. (4)
Keller, Michael L. (16)
Keller, Rudolph J. (9)
Kelley, Charles B. P. (2)
Kelley, Ray H. (16)
Kelly, Bernard S. (9)
Kelly, Harry R. J. (9)
Kelly, Leo J. (12)
Kemeny, George (20)
Kemeny, Imre (12)
Kempe, George (7)
Kennedy, A. Andrew (16)
Kennedy, Eugene T. (16)
Kennedy, John N. (20)
Kennedy, John W. (9)
Kennedy, Paul A. (2)
Kennedy, William M. (7)
Kenney, John A. (7)
Kent, Donald F. (14)
Kent, Louis R. (20)
Keppler, Charles, Jr. (16)
Kerdasha, Richard F. (4)
Kern, E. Clarence (7)
Kern, Meyer J. (7)
Kerns, Francis J. (7)
Kessell, John S. (7)
Kessler, Edward I. (14)
Kessler, Henry B. (7)
Kessler, Henry H. (7)
Keyser, David (4)
Kidd, Ruth W. (20)
Kiely, Eugene M. (9)
Kiessling, Charles E. (7)
Kiley, John E. (7)
Kilts, Winfield S. (2)
Kim, Gay B. (16)
Kimler, William D. (4)
Kimmel, Charles (7)
Kimmel, M. Leonard (9)
Kimmel, Seymour S. (21)
Kinczel, John A. (11)
King, Alden P. (14)
King, Louis I. (7)
Kingma, John G. (2)
Kingslow, George L. (2)
Kinley, John W. (7)
Kinney, Albert G. (4)
Kinney, Burton O. (16)
Kirkby, Cyril S. (7)
Kirkman, Leroy G. (7)
Kirkwood, Allan S. (7)
Kirschner, Martin I. (19)
Klapper, Lester L. (20)
Klarich, Philip (4)
Kleiber, Estelle E. (12)
Klein, Allan (9)
Klein, Andrew J. V. (7)
Klein, Edward C., Jr. (7)
Klein, Edward F. (12)
Klein, Julius (9)
Klein, Milton (14)
Klein, Solomon (14)
Klein, William (12)
Kleinberger, Harry H. (7)
Kleiner, Samuel (16)
Kleinman, Maurice (7)
Kleinmann, Eberhart H. (16)
Klempner, Paul (11)
Klenk, Joseph P. (7)
Kler, Joseph H. (12)
Kline, George L. (7)
Kline, Herman (1)
Kline, Joseph J. (11)
Kline, Oram R. (4)
Klinger, John S. (4)
Kloby, John J. (20)
Klosk, Emanuel (7)
Klughaupt, Dorothy K. (16)
Knapp, Richard E. (2)
Knapp, Victor (13)
Knauer, Charles H., Jr. (11)
Knauer, George (20)
Knight, Richard vanD. (20)
Knight, William T. (2)
Knowles, George M. (2)
Knowles, James S. (6)
Knox, Charles A. (2)
Knox, Harriet L. (2)
Knox, Howard A. (10)
Kobes, John J. (7)
Koch, James (7)
Koch, William (13)
Koeck, George P. (7)
Koelsch, Frederick J. (12)
Koenig, Bertram (16)
Koerber, George (16)
Kohn, Joseph J. (11)
Kohn, Leo (7)
Kohn, Ralph B. (11)
Kohut, George J. (12)
Kolb, John M. (9)
Kolbe, Joseph T. (6)
Kolodin, Abraham (7)
Kondor, Joseph S. (11)
Konzelman, Henry J. (20)
Konzelmann, Frank W. (1)
Kooperstein, Samuel I. (9)
Koplin, Nathaniel H. (11)
Korman, Arnold (16)
Kornfeld, Werner (7)
Kornfield, Norman B. (9)
Kossmann, Walter J. (14)
Kosterlitz, Henry H. (7)
Kovaleski, Walter A. (16)
Kovin, Abraham (16)
Kraemer, Manfred (7)
Kraemer, Samuel H. (9)
Krafchik, Louis L. (12)
Kraissl, Cornelius J. (2)
Kraker, David A. (7)
Kramer, Bernard M. (12)
Kramer, Douglas W. (20)
Kramer, Samuel E. (12)
Krans, Edward S. (20)
Krasnitz, Alexander (3)
Kratka, William H. (6)
Krauss, Fletcher I. (14)
Krausz, Emery (21)
Kraut, Arthur M. (9)
Krechmer, Abraham (1)
Kresch, Philip (9)
Kreutz, Paul J. (20)
Krichbaum, Carroll E. (7)
Krieger, George (16)
Kristal, John (2)
Krohn, Marc (13)
Krone, William F. (7)
Krug, Alfred J. (7)
Kruger, William (7)
Krugman, Benjamin M. (16)
Kuchlewski, Edward J. (20)
Kuder, Joseph M. (3)
Kuhlmann, Alvin E. (9)
Kuite, George B. (14)
Kummel, Max (7)
Kump, Albert B. (6)
Kun, Bertram (9)
Kunz, Harold G. (7)
Kuperman, Henry L. (7)
Kurtz, Geza R. (9)
Kushner, Alexander (20)
Kustrup, John F. (11)
Kutner, Charles (4)
Kyle, Ernest I. (20)

ASSOCIATE MEMBERS

Kaman, Samuel L. (1)
Kant, Emanuel R. (12)
Kaplan, Harry (11)
Kassel, Mortimer H. (2)
Katzenbach, C. Buckman (11)
Kawalek, Roman (7)
Kenny, James (7)
Keyssar, Alexander (7)
Kimche, Irwin (7)
Klein, Michael (7)
Knowles, Frederick (13)
Koenig, Robert E. (12)
Kollar, Charles S. (2)
Kren, Frank (11)
Kunderman, Philip J. (12)

L

ACTIVE MEMBERS

Laauwe, Harold W. (16)
La Barba, Peter J. (2)
Labow, Joseph J. (20)
Ladas, George (20)
Lafferty, Elton B. (7)
Lakiszak, Roman T. (9)
Lamberto, Vito A. (2)
Lance, Elton W. (20)
Landaw, Louis (16)
Landes, Edwin W. (19)
Landesman, William (7)
Landis, Harry P., Jr. (3)
Landry, Ernest J. (20)
Landshof, Charles A. (9)
Lane, Austin W. (7)
Lane, Edgar W. (10)
Lane, Edgar W., Jr. (10)
Lane, Milton (20)
Lane, Thomas F. (9)
Lang, Joseph (12)
Lang, Louis (20)
Lang, Paul (6)
Lang, Richard E. (16)
Lange, Louis C. (9)
Langston, Junius T. (20)
Lapin, Louis P. (11)
Lapin, Mathew R. (11)
Largay, Arthur O. (9)
Larkey, Irving G. (7)
La Rosa, Frank J. (8)
Larossa, Ernest A. (4)
Larrabee, Callie H. (20)
Larson, Henry M. (14)
Lathrop, Frederic W. (20)
Lathrope, George H. (14)
Laudig, Guy H. (14)
Lavine, Barney D. (11)
Lavine, Samuel C. (12)
Lavine, Sidney B. (11)
Lawless, Edward T. (16)
Lawrence, Arthur C. (16)
Lawrence, Elias D. (16)
Lawrence, William H. (20)
Lawsing, G. Conde (9)
Lawther, Boyd M. (1)
Lazow, S. Manlius (12)
Leach, John E. (16)
Leaman, Granville M. (7)
Leaver, Morris H. (10)
Le Bel, Louis J. B. (7)
Leber, Otto H. (7)
Lee, Benjamin F. (4)
Lee, Frederick P. (16)
Lee, John J. (7)
Lee, Robert E. (7)
Lee, Thomas B. (4)
Lee, William A. (9)
Leeds, Leonard W. (7)
LeFavor, Dean H. (3)
Leff, Abraham (7)
Leff, Charles O. (7)
Leff, William A. (7)
Lefkovics, Sidney C. (7)
Leggett, Lindley H., Jr., (20)
Leggett, Thomas H., Jr. (20)
Lehmacher, Frank (15)
Lehman, David J., Jr. (7)
Lehman, Irving J. (7)
Leir, J. Krevin (9)
Lemay, Albert T. (16)
Lemkin, Samuel (7)
Lemmerz, Willard H. (2)
Lemmon, Junius M. (21)
Lempke, Richard J. (9)
Leonard, Bernard (3)
Leonard, George F. (12)
Leonard, Isaac E. (1)
Leonard, Isaac E., Jr. (1)
Leonard, Lothair L. (13)
Leone, Peter P. (20)
Lepis, A. Albert (9)
Lepree, Joseph A. (20)
Lerman, Frederick (20)
Lerman, Irving (20)
Leshin, Harry (11)
Lesko, Stephen W. (2)
Lettiere, Anthony J. (11)
Levendusky, Daniel E. (14)
Levin, Jack (13)
Levin, Joseph (7)
Levin, Murray (7)
Levine, David B. (16)
Levine, Edward P. (7)
Levine, G. Irving (9)
LeVine, Israel (16)
Levine, Philip (7)
Levine, Sidney C. (16)
Levinsohn, Sandor A. (16)
Levinson, David M. (7)
Levinson, Louis J. (7)
Levinson, Reuben (12)
Levinson, Robert M. (7)
Levison, William (7)
Levitas, George M. (2)
Levitas, Irving M. (2)
Levitt, Jesse N. (7)
Levy, Abram (18)
Levy, Anna L. (7)
Levy, David (16)
Levy, Herman (16)
Levy, Irvin (11)
Levy, Jack D. (2)
Levy, Julius (7)
Lewandowski, Edmund E. (7)
Lewis, Albert (20)
Lewis, Alexander (20)
Lewis, Alice B. (2)
Lewis, Collins E. (12)
Lewis, G. Rae (7)
Lewis, Jacob (13)
Lewis, Thomas K. (4)
Liana, Stephen M. (16)
Liccese, Emanuel (7)
Licks, Frederick C. (7)
Liddell, Raymond N. (18)
Lieb, Robert L. (7)
Lieb, Saul (7)
Lieberman, David P. (20)
Lieberman, Milton L. (20)
Lieberson, Leonard (9)
Liegner, Ben (7)
Light, Arthur B. (11)
Lilien, Bernard B. (7)
Lilien, Milton (7)
Lilien, Milton M. (20)
Lima, John G. (16)
Linares, A. Carfi (16)
Lincoln, Jennings S. (7)
Lind, Zoltan H. (12)
Linden, Mortimer H. (9)
Lindroth, Lawrence V. (9)
Linke, James J. P. (20)
Lintz, Sidney Z. (8)
Linz, Curt (7)
Lipkin, Isadore (17)
Lippincott, Lansing Y. (20)
Lippman, Harold (7)
Lippman, Nathan L. (1)
Lipshutz, Charles (9)
Lipstein, William (7)
Lipton, Louis (16)
Lisanti, Gaetano (9)
Little, Alonzo W. (9)
Little, Rufus R. (2)
Little, William R. (11)
Littwin, Charles (2)
Liva, Arcangelo (2)
Liva, G. Albin (2)
Liva, Paul F. (2)
Livengood, Baxter A. (8)
Livengood, Horace R. (20)
Livingston, Bernard (7)
Livingston, Paul (7)
Lloyd, Samuel J. (11)
Lobban, Robert B. (9)
Lobsenz, Nathan P. (16)
Locke, Henrik W. (4)
Loder, Horace B. (6)
Loder, Joseph S. (7)
Loeser, Lewis H. (7)
Lohman, Herman (7)
Loman, Samuel G. (2)
Lomauro, James R. (16)
Lombardi, Frank L. (2)

Lomhoff, Irving I. (7)
London, Jules R. (16)
London, Leslie (16)
London, William (12)
Londrigan, Joseph F. (9)
Londrigan, Joseph F., II (9)
Long, Elias E. (13)
Long, John F. (7)
Long, Miles T. (9)
Long, Pauline A. (12)
Longnecker, John E., Jr. (19)
Longo, James J. (7)
Longsdorf, Harold E. (3)
Longshore, Walter E., Jr. (7)
Loper, John C. (6)
Lord, C. Donald (2)
Lore, Harry E. (6)
Losada, Camella A. (20)
Love, Elizabeth F. (3)
Lovell, John F. (7)
Lovett, Irving K. (13)
Lovett, Joseph C. (4)
Low, Donald B. (16)
Lowe, Louise (2)
Lowell, Milton E. (20)
Lowenstein, Aaron (7)
Lowenstein, Ernest C. (20)
Lowenstein, Harry A. (7)
Lowits, Otto (7)
Lowrey, James H. (7)
Luban, Benjamin (7)
Luca, Frank (13)
Luca, Mildred O. (13)
Lucas, Stanley L. (1)
Lucas, W. Fred (3)
Luce, Henry A. (7)
Lucent, S. Bell (16)
Lucey, James J. (12)
Luczynski, Edward W. (9)
Luddecke, Hugh F. (14)
Lufburrow, Charles B. (20)
Luippold, Eugene J., Jr. (14)
Luksteid, Casimir J. (16)
Lummis, Clarence P. (17)
Lundblad, Walter E. (7)
Luongo, Federico (7)
Lupin, Edward E. (9)
Lupo, Domenico (7)
Luria, Sanford A. (2)
Lurie, Solomon I. (7)
Lurie, Wolf (7)
Lushear, Frank H. (19)
Lussier, Georges H. (13)
Lutz, William M. (7)
Lyerly, James M. (20)
Lynch, Albert E. O. (7)
Lynch, Donald C. (11)
Lynch, Edward T. (20)
Lynch, Maurice M. (2)
Lynch, Michael F. (20)
Lynch, Roland J. (9)
Lynn, Hugh B. (7)
Lynn, Irving I. (9)
Lyon, Archibald (7)
Lyon, Earl C. (6)
Lyons, James V. (7)
Lyons, Romola L. K. (2)

ASSOCIATE MEMBERS

LaCaille, Rupert A. (7)
Larkin, Michael J. (11)
Laufenberg, Joseph W. (11)
Ledden, Lewis J. (11)
Legg, George E. (16)
Leon, Jerome L. (7)
Leon, Maurice J. (7)
Leonard, Martha F. (12)
Liva, Vinicio G. (2)
Livingston, Elias (7)
Lombardo, Bartlo (7)
London, Isabel M. (12)
Lynch, Cornelius G. (11)

M

ACTIVE MEMBERS

Maas, Max A. (7)
Mabey, J. Corwin (7)
MacAlpine, Kenneth B. (4)
Macaluso, Dominic C. (7)
MacArt, J. Harold (7)
MacArthur, Clymont (7)
Macaulay, Francis A. (2)
MacBrayer, Reuben A. (20)
Macchia, Benjamin J. (9)
MacDermid, Lynden E. (11)
MacDonald, Edward O. (20)
Mace, Margaret (5)
MacGahan, William H. (16)
MacGregor, Allan W. (16)
MacGuffie, Robert N. (16)
Machkowsky, Edwin (9)
MacKellar, James M. (2)
MacKenzie, Robert A. (13)
Mackes, Claude B. (17)
Mackin, John J. (9)
Mackler, Harry S. (20)
Mackler, Meyer E. (16)
MacLaren, Philip J. (2)
Maclay, Joseph A. (16)
MacMillan, C. Wright (7)
Macpherson, Elwood H. (7)
Madaras, John S. (9)
Maddren, Russell F. (2)
Mader, A. Ivan, Jr. (2)
Madison, L. Keith (9)
Maffeo, Carl E. (7)
Maffongelli, Joseph A. (16)
Magee, Edward S. (4)
Magee, Harold S. (11)
Magee, Russell S. (4)
Magee, William P. (2)
Maggio, George A. (7)
Maggio, Nicholas A. (7)
Maggio, Ross J. (20)
Magill, Marcus (1)
Magnes, Max (16)
Magolda, Anthony F. (6)
Magovern, Thomas F. (7)
Magson, Albert E. (11)
Mahaffey, J. Lynn (4)
Maher, John E. (13)
Mahood, Herbert L. (7)
Maisel, Irving (7)
Majeski, Henry J. (11)
Major, Morton M. (1)
Makarchek, Sigmund J. (7)
Makin, John B. (13)
Malatesta, Charles S. (20)
Maldeis, Albertos M. K. (4)
Mallnowski, John (9)
Mallison, Herbert (20)
Mamlet, Alfred M. (7)
Manahan, Daniel V. (13)
Mancene, Edward M. (2)
Mancusi-Ungaro, Elviro (7)
Mancusi-Ungaro, Lodovico (7)
Manette, Milton (9)
Manfro, Gerard J. (7)
Manly, Thomas E. (16)
Mangogna, Phllip (12)
Mann, Benjamin (12)
Mann, Jacob J. (12)
Manning, John W., (20)
Manser, Ernest E. (4)
Manzione, Frank A. (16)
Marcarian, Henry G. (4)
Marchione, Nicholas E. (6)
Marcus, Bernard (18)
Marcus, Donald (7)
Marcus, Kurt (9)
Margaretten, Edward I. (12)
Margolis, Alfred (7)
Margulies, Charles (7)
Marin, Robert B. (7)
Marini, Dominick (16)
Mark, Harold I. (2)
Mark, Harry B. (3)
Mark, Joseph S. (12)
Markel, Albert G. (16)
Markley, Luther A. (2)
Markowitz, Benjamin B. (9)
Markowitz, Irwin B. (9)
Markowitz, Isidor (5)
Markowitz, Louis (16)
Marks, Zelda I. (7)
Marlett, Neumann C. (21)
Marone, Carmine R. (20)
Maroney, James H. (20)
Marquis, Dean W. (7)
Marquis, W. James (7)
Marra, Rocco S. (7)
Marrella, Louis F. (9)
Marrocco, William A. (16)
Marshall, Frank A. (9)
Marshall, H. Donald (1)
Martin, Theodore (16)
Martin, Willlam E. (20)
Martin, Willlam P. (7)
Martland, Harrison S. (7)
Marts, George H. (20)
Marvel, Peter H. (1)
Marvel, Philip, Jr. (1)
Marvin, Dorothy H. (12)
Marx, Frederick J. (2)
Masciocchi, Thomas A. (7)
Masiello, Carmine J. (9)

Mason, Alvin S. (17)
Mason, James H. (1)
Mason, Virgil A. (7)
Massengill, Fulton (7)
Massey, J. Bruce (7)
Masterson, John F. (7)
Mastroianni, Frank M. (20)
Mastromonaco, Joseph D. (9)
Masucci, Alberico (16)
Matheke, George A. (7)
Matheke, Otto G. (7)
Matheke, Otto G., Jr. (7)
Mathesheimer, Jacob L. (9)
Matheson, Gilchrist E. (7)
Mathews, Raymond H. (14)
Mathews, William J. (9)
Matthews, Clifford B. (7)
Matthews, Leonard M. (16)
Matthews, William (13)
Matthews, William F. (7)
Matturri, Dominick A. (9)
Mauer, Richard E. (7)
Maurer, K. Virginia (7)
Maurer, Martha E. (20)
Maver, William W. (9)
May, Ernst A. (7)
Mayhew, Charles H. (6)
Mazur, Edward F. (3)
Mazzarella, Carlo (16)
Mazzotta, Samuel (5)
McAlpine, Paul (20)
McAveney, Thomas F. G. (7)
McBride, Andrew F., Jr. (16)
McCall, Jesse (19)
McCallion, William H. (20)
McCallum, Arthur S. (4)
McCarroll, E. Mae (7)
McCarron, James A. (9)
McCarthy, Arthur M. (4)
McCarthy, George L. (16)
McCarthy, John J. (9)
McCarthy, William P. (11)
McCauley, Francis J. (7)
McClintock, Elsie (20)
McCluskey, Harry B. (14)
McConaghy, Thomas P. (4)
McCorkle, William E. (10)
McCormack, Frank C. (2)
McCormick, James E. (7)
McCormick, William H., Jr. (12)
McCracken, Josiah C. Jr. (1)
McCreight, David W. (13)
McCroskery, James H. (7)
McCue, John B. (16)
McCullough, John H. (11)
McCurdy, Robert G. (13)
McDermott, Vincent T. (4)
McDonald, Richard J. (16)
McDonnel, Gerald E. (3)
McDonnell, George J. (13)
McFeely, Percy R. (2)
McGeehan, Stanley M. (1)
McGinn, William J. (20)
McGlade, Thomas H. (4)
McGovern, John F., Jr. (12)
McGovern, Patrick J. (9)
McGuigan, Francis A. (11)
McGuinn, William B. (7)
McGuire, John J. (7)
McIlveen, Marion (2)
McKeever, William J. (9)
McKelvie, Julius C. (13)
McKeown, George H. C. (7)
McKiernan, Robert L. (12)
McKim, William F. (7)
McKinley, C. Scott (18)
McKinstry, John W. (12)
McLane, A. Donald (2)
McLaughlin, Thomas F. (12)
McLaughlin, William B. (7)
McLean, Hugh A. (9)
McLellan, George A. (7)
McLeod, Harry J. (2)
McLeod, Neill S. (12)
McLoughlin, Frank J. (9)
McLoughlin, John W. (9)
McMahon, Bernard C. (14)
McMurtrie, William A. (14)
McNenney, Claudio E. (9)
McPherson, Malcolm E. (16)
McTague, Robert S. (13)
McVay, Edward A. (7)
McVeigh, Charles J. D. (19)
McWilliams, Charles E. (4)
Means, Paul B. (11)
Mears, William G. (2)
Mecray, Paul, Jr. (4)
Mecray, Paul M. (4)
Medd, John C. (7)
Meehan, George E. (9)
Meehan, Martin M. (7)
Meeker, Irving A. (7)
Meeker, John L. (20)
Megibow, Harold J. (2)
Meier, William U. (16)
Meineke, William C., Jr. (20)
Meinhard, Fred (7)
Meinzer, Martin S. (12)
Meisel, David B. (7)
Mele, Vincent (7)
Mellen, Stanley H. (7)
Meloney, Lester F. (16)
Meltsner, Louis (9)
Meltzer, Louis (9)
Melvin, Daniel G. (14)
Menden, Julian (14)
Mendenhall, Clinton D. (3)
Meneve, Alfred D. (16)
Menge, Carl H. (15)
Menk, Paul E. (7)
Mensch, Harvey G. (20)
Merendino, Anthony G. (1)
Merkelbach, Walter P. (7)
Merliss, Eugene (7)
Merlo, Francis A. (20)
Merlo, Francis V. (20)
Mermod, Camille (7)
Merrick, Evelina (7)
Merrill, Charles F. (12)
Merrill, Edwin D. (10)
Merselis, John G. (7)
Mersheimer, Christian H. (9)
Messina, Thomas (7)
Messinger, Samuel (12)
Metsky, Joseph (7)
Metzer, Emma P. W. (3)
Metzer, Freeman W. (3)
Meurlin, Alfred (7)
MeVay, James C. F. (1)
Meyer, George P. (4)
Meyer, Howard M. (2)
Meyer, William (9)
Meyers, Francis R. (16)
Meyerson, Noah (9)
Mezzetti, Alfred F. (6)
Michell, George E. (21)
Michelson, Henry (16)
Mickewich, Stephen A. (9)
Miele, Frank A. (13)
Mierau, Ernest W. (7)
Milano, Cesare A. (1)
Miller, Earle K. (11)
Miller, Eugene L. (7)
Miller, George M. (20)
Miller, Gerald H. (11)
Miller, H. Garrett (6)
Miller, Herbert G. (2)
Miller, Herman P. (7)
Miller, I. Irwin (7)
Miller, Joseph A. (7)
Miller, Lewis H. (17)
Miller, Lucille F. (7)
Miller, Max H. (9)
Miller, Nathan (7)
Miller, Ralph (7)
Miller, Raymond E. (11)
Miller, Reginald C. (11)
Miller, Robert B. (9)
Miller, Robert M. (20)
Miller, S. David (12)
Miller, Samuel R. (11)
Miller, William H. (17)
Milliser, Estelle T. (20)
Mills, Charles S. (3)
Mills, Clifford (14)
Mills, Stephen D. (20)
Minard, Edwy L. (7)
Minier, Carl L. (7)
Miningham, William D. (7)
Minnefor, Charles A. (7)
Minnella, Thomas J. (20)
Minschwaner, Geo. G., Jr. (11)
Mintz, Alvin R. (14)
Miranti, Paul J. (9)
Mishler, Jay E. (1)
Misko, Albert (18)
Missonellie, William (16)
Mitchell, Augustus J. (7)
Mitchell, Charles H. (11)
Mitchell, Charles R. (16)
Mitchell, Walter L., Jr. (7)
Mitchell, Willis B. (15)
Mitskas, Theodore V. J. (11)
Modarelli, Walter H. (9)
Modeski, Chester J. (7)
Modny, Michael T. (7)
Modrys, Walter F. (2)
Moeckel, Clarence W. (7)
Mohair, John P. (13)
Mohr, Frank L. (20)
Moir, John A. (5)
Molitch, Matthew (1)
Monaco, Saverio A. (7)
Monaloy, Morris A. (16)
Moncada, Salvatore (7)
Monfort, Robert N. (9)
Monica, Louis A. (9)
Monosson-Friedland, Ida (5)
Moon, Alexander C. (5)
Moon, Dabney vonK. (20)
Moore, Dean C. (7)
Moore, J. Leonard (11)
Moore, John P. (7)
Moore, Ralph L. (8)
Moran, John F., Jr. (10)
Mores, Herbert R. (2)
Moress, Edward J. (7)
Moretti, John J. (7)
Morgan, Browne (7)
Moriarty, John F. (9)
Moricl, Theodore (16)
Moriconl, Albert F. (11)

Morley, Grace C. (9)
Morrill, James P., Jr. (16)
Morris, Carlyle (12)
Morris, David G. (9)
Morris, Karl E. (20)
Morris, Thomas M. (20)
Morris, Watson B. (20)
Morrison, Frederick H. (19)
Morrow, J. Lloyd (2)
Morrow, Joseph R. (2)
Morton, Thomas V., Jr. (7)
Moscoe, Harry A. (16)
Moss, Jack W. (2)
Mott, Joseph E. (16)
Motzenbecker, Peter F. (7)
Mount, Walter B. (7)
Mountford, William E. (11)
Muccia, John J. (9)
Mueller, George H. (9)
Muldoon, Edward J. (3)
Mulford, William P. (3)
Muller, Frederick L. (2)
Mulligan, Edward W. (13)
Mulligan, Luke A. (2)
Mullin, Eugene F. (7)
Mullin, Raymond J. (7)
Mullins, Roy L. (10)
Mulvihill, William J. (9)
Munro, Charles A. (3)
Munro, Jeannette (11)
Murn, Charles J. (16)
Murphy, Albert T. (20)
Murphy, Charles M. (13)
Murphy, Herschel S. (20)
Murphy, James A. (11)
Murphy, James M. (9)
Murphy, Leo J. (9)
Murphy, Patrick H. W. (9)
Murphy, Thomas W., Jr. (7)
Murray, Clifford K. (1)
Murray, Edwin N. (4)
Murray, Harrold A. (7)
Murray, Joseph A. (9)
Murray, Norman L. (20)
Murto, Thomas V. (11)
Musetto, Carmelo A. (14)
Mustermann, Otto H. (9)
Musulin, Nicholas R. (4)
Muttart, George W. (9)
Mutter, Alfred A. (9)
Myatt, Leslie E. (6)
Myers, Norman V. (2)

ASSOCIATE MEMBERS

Mabee, John R. (16)
Malis, Leonard I. (1)
Mancusi-Ungaro, Harold (7)
Manrodt, Kurt, Jr. (16)
Marino, Benjamin (12)
Mason, John T., Jr. (7)
Mason, Stuart A. (2)
Mather, William B. (11)
Mazzei, Armand S. (13)
McCroskery, Hamilton M. (7)
McGahan, Joseph L. (1)
McGreevey, Harold (13)
McWhorter, John E. (2)
Meer, Nadhim E. (16)
Merk, Anthony (7)
Miller, Florian C. (12)
Moolten, Sylvan E. (12)
Moore, William J. (11)
Morgenstern, Mates (12)
Murphy, Arthur G. (7)
Murray, Edward F. (7)
Myer, Clifton G. (12)

N

ACTIVE MEMBERS

Nacca, Carl A. (7)
Nadel, Charles I. (7)
Nadler, Arthur A. (20)
Nafash, Shafeek (9)
Nafey, Herbert W. (12)
Naidorff, Saul A. (20)
Nalitt, David I. (9)
Nappi, Pasquale E. (7)
Nash, Alexander E. (7)
Nash, Herman S. (7)
Nataro, Joseph (7)
Nataro, Maurice (7)
Nathanson, Norman (13)
Naulty, Charles W., Jr. (12)
Navazio, Attilio (14)
Nayfield, Ronald C. (11)
Neal, Charles B. (6)
Neander, David G. (17)
Neary, Edward R. (2)
Neer, William (16)
Neiderhoffer, Sydney L. (13)
Nelson, Francis B. (20)
Nemiroff, Nathan (2)
Nemirow, Martin (16)
Nemzek, William P. B. (7)
Nesbitt, Elizabeth (16)
Nestor, John (19)
Netz, Lester W. (2)
Neumann, Alfred (20)
Nevins, Thomas F., Jr. (9)
Nevius, John K., Jr. (20)
Nevius, William B. (7)
Newbury, Graham C. (20)
Newcomb, Marcus W. (3)
Newman, Grace T. (7)
Newman, Julius (7)
Newmeyer, Joseph (4)
Ney, J. Marshall (7)
Nichols, Frank I. (2)
Nichols, Stanley H. (13)
Nicholson, Frank P. (9)
Nickman, E. Harrison (1)
Nicol, Lorenz C. (2)
Nicola, Toufick (7)
Nicoll, George L. (14)
Nieman, Solomon Z. (12)
Niemtzow, Frank (13)
Nimaroff, Meyer (7)
Nittoli, Rocco M. (20)
Nobile, James J. (9)
Noll, Louis (7)
Nonziato, Frank A. (11)
Normand, Alphone F. (12)
Norris, Alfred W. (16)
Norton, James F. (9)
Norval, William A. (16)
Notkin, Meyer (16)
Novello, Joseph A. (20)
Novich, Max (7)
Nussbaum, Harvey E. (7)
Nussbaum, Joseph (20)
Nussbaum, Nathan (16)
Nye, Howard H. (16)
Nyiri, William A. (7)
Nyvall, Pierre J. (15)

ASSOCIATE MEMBERS

Naame, John M. (1)
Naclerio, Amedeo (2)
Nelson, Clifford H. (7)
Newmann, Monroe E. (2)
Niemiera, Alexander K. (12)
Novak, John G. (7)
Nuzzolo, Charles A. (16)

O

ACTIVE MEMBERS

Oberlander, Gertrude (7)
Obert, J. Edwin (15)
Obester, Gabriel E. (20)
O'Brian, Dennis M. (16)
O'Brian, Jeremiah H. (16)
O'Brien, Edwin J., Jr. (20)
Ockene, Abraham (9)
O'Connell, James J. (12)
O'Connor, Bernard A. (7)
O'Connor, Dennis F. (7)
O'Connor, Michael J. (7)
O'Connor, Paul A. (7)

O'Crowley, Clarence R. (7)
Oderr, Charles (20)
Oesterreicher, Desider (9)
Oestreicher, Harry (14)
Offenkrantz, Frederick M. (7)
Ogden, Andrew E. (11)
Ogden, Michael A. (16)
O'Grady, Michael J. (7)
O'Hanlon, George (9)
Okin, Irving (16)
Olini, Joseph J. (7)
O'Lini, Louis J. (7)
Olpp, Archibald E. (9)
Olpp, John L. (2)
Olson, Vendela E. (2)
Ondovchak, M. Frederic (4)
O'Neill, Charles L. (7)
O'Neill, Charles L., Jr. (7)
O'Neill, Joseph F. (11)
Onorato, Vincenzo R. (7)
Opdyke, Gordon M. (7)
Openchowski, Mieczyslaw (7)
Opfermann, John L. (13)
Opper, Philip (16)
Oram, Joseph H. (16)
Oransky, Marvin (7)
Oren, Hyman (2)
Orloff, Samuel (7)
Ormsby, Thomas J. (7)
Ornaf, I. Edward (4)
O'Rourke, James J. (11)
Orris, Harold J. (7)
Ortolano, James J. (9)
Orton, Foster (20)
Orton, George L. (20)
Orton, Henry B. (7)
Orton, Stuart (20)
Osborn, A. Downey (13)
Osborn, Edward G. (4)
O'Shea, John J. (9)
Osher, Morris M. (20)
Oshrin, Henry (9)
Ostrowski, Sigismund J. (7)
Outwin, Richard N. (7)
Owen, Philip (20)

ASSOCIATE MEMBERS

Ott, Franklin B. (7)
Ozier, Charles W. (16)

P

ACTIVE MEMBERS

Padden, Aloysius F. (2)
Paddock, Royce (7)
Padney, Edward V. (9)
Pagano, Peter (2)
Pagliughi, John J. (9)
Palazzo, William L. (14)
Palin, George (20)
Palladino, Alessandro (6)
Pallen, Conde deS. (2)
Palma, Nicholas (16)
Palmer, Francis R. (16)
Palmer, Gideon H. (7)
Palmer, Henry S. (7)
Palmisano, Vincent S. (4)
Panigrosso, Louis R. (12)
Panitch, William (7)
Pannullo, John N. P. (7)
Pansy, Abraham A. (12)
Pantaleone, Joseph (11)
Papera, John J. (7)
Parent, Sol (7)
Paris, William (16)
Parker, Albert F. (17)
Parker, Horace N. (11)
Parker, John E. (7)
Parkes, Morey (7)
Parry, Allen A. (14)
Parry, Antoinette R. (14)
Parry, Oliver K. (13)
Parsonnet, Aaron E. (7)
Parsonnet, Eugene V. (7)
Pascall, Thomas M. (7)
Pasternack, Elroy (16)
Pastore, Mario (6)
Patella, Fulvio (16)
Patterson, Isaac N. (8)
Patti, Frank A. (2)
Patton, Paul B. (19)
Pattyson, Ralph A. (7)
Paul, George A. (7)
Paul, H. Carl (7)
Pauly, Arthur N. (18)
Pavia, John R. (7)
Payne, Guy (7)
Payne, Guy, Jr. (7)
Peacock, Arthur B. (3)
Pearl, Sydney S. (20)
Pearlstein, Frank (9)
Pearson, J. Gerald (12)
Peckman, Abram (9)
Pecora, Carmine L. (15)
Pecora, Samuel (7)
Pedevill, Joseph R. (2)
Pedrick, William W. (8)
Peer, Lyndon A. (7)
Pegau, Paul M. (8)
Pellecchia, Leonard J. (7)
Pellegrini, Vincent J. (2)
Pellet, Thomas L. (19)
Pellicane, Anthony J. (12)
Pelliciari, Donald (7)
Penchansky, Samuel J. (9)
Pendexter, Sidney E. (7)
Pennington, Alfred W. (7)
Pennington, John (1)
Pentecost, Salvador D. (7)
Pentel, Louis S. (9)
Pepe, Salvatore A. (11)
Perez, John F. (1)
Perham, Bertram S. (7)
Perham, Roy G. (2)
Perkel, Louis L. (9)
Perlberg, Harry J. (9)
Perlmutter, Irving K. (7)
Permison, Michael (7)
Pernetti, Anthony M. (16)
Perrine, Cornelius C. (13)
Perrone, Anthony J. (7)
Perrotta, Anthony J. (13)
Perry, Frank L. (17)
Pessel, Johannes F. (11)
Peters, Edgar A. P. (9)
Peters, Richard C. (20)
Peterson, Charles A. (9)
Peterson, Walter R. (11)
Petinga, Thomas J. (1)
Petrone, Peter A. (7)
Petry, William (7)
Pettit, Harry H. (2)
Pettit, Herschel (5)
Phelan, Walter F. (20)
Phelps, James E. (16)
Phillips, Algernon A. (7)
Phillips, Claude B. (4)
Phillips, Walter (2)
Piampiano, John (19)
Piasecki, Chester A. (16)
Picardi, Armand A. (7)
Pieper, Howard C. (13)
Pierson, Carl L. (11)
Pierson, Joseph R. (11)
Pietri, Raoul (13)
Pignataro, Frank P. (13)
Pigott, Albert W. (18)
Pike, Charles E. (4)
Pilch, Arthur G. (7)
Pilkington, Albert (1)
Piller, Jacob (16)
Pilloni, Louis (7)
Piltz, George F. (9)
Pinckney, Frank H. (14)
Pincus, Isidore (7)
Pindar, Frederick S. (9)
Pindar, Irene D. (2)
Pinerman, Robert B. (11)
Pingitore, Eufelia (2)
Pink, Solomon H. (16)
Pino, Anthony (6)
Pinsky, Harry A. (4)
Pinto, Joseph A. (7)
Pitman, Mason W. H. (18)
Pittman, Allen R. (11)
Pizzi, Francis W. (7)
Pizzi, Mario V. (7)
Pizzi, Peter J. (2)
Placa, James A. (2)
Plant, James S. (7)
Platt, Thomas H. (12)
Plavin, Nathan J. (9)
Pleasants, Edward N. (13)
Plinke, Fritz W. (16)
Plume, Clarence A. (14)
Podell, A. Alfred (13)
Pogg, Raymond C. (20)
Pogoloff, Samuel H. (18)
Pois, John (7)
Poland, George A. (1)
Poleshuck, Rubin (20)

Policastro, Nelson C. (2)
Polizzotti, Joseph L. (16)
Polk, Charles C. (20)
Pollack, Louis (20)
Pollack, Sol (20)
Pollak, Berthold S. (9)
Poller, Frederick K. (7)
Pollis, Nicholas L. (7)
Pollock, Samuel L. (7)
Pollock, Theodore (16)
Polow, Benjamin (7)
Polowe, David (16)
Pomeranz, Raphael (7)
Pons, Carlos A. (13)
Pontery, Herbert B. (9)
Potter, Benjamin P. (9)
Potter, Charles W. (21)
Potter, Ellen C. (11)
Potter, Raymond T. (7)
Pottinger, William E. (14)
Povalski, Alexander W. T. (9)
Powell, Robert J. (1)
Powis, Ethel M. (11)
Poyas, Morton L. (11)
Prager, Bert A. (14)
Prall, Henry E. (2)
Prather, John W. (2)
Pratt, Arthur G. (4)
Prazak, Beatrice (20)
Preece, John D. (11)
Pregnall, James P. (13)
Prestifilippo, Silvestro (7)
Preston, Perry B. (7)
Price, Charles W. (7)
Price, H. Preston (9)
Price, Henry S., Jr. (4)
Prince, Robert A. (16)
Prince, Samuel (9)
Principato, Roberto (4)
Probst, Everett W. (7)
Proctor, Francis E. (11)
Proctor, Jesse E. (7)
Protzman, Thomas B. (2)
Proudfoot, Perry A. (20)
Prout, William B. (2)
Provenzano, Samuel (7)
Provisor, Benjamin (16)
Prunetti, Carmen (11)
Purcell, Ernest F. (11)
Purdy, Charles H. (9)
Pusin, Max (9)
Putter, Eric (12)

ASSOCIATE MEMBERS

Palmeri, Anthony (16)
Panzer, Norman (7)
Parker, Paul (11)
Pasquale, Thomas L. (7)
Paul, Abraham (1)
Payne, Douglas (13)
Pedicini, Joseph L. (7)
Perlman, Maximilian (7)
Perr, Herbert M. (7)
Persico, Anthony (2)
Pfeffer, Burton B. (16)
Philpel, Michael (7)
Pickar, Gabriel (12)
Pinck, Bernard (16)
Pindar, William A., Jr. (2)
Pisani, Anthony A. (13)
Pogue, Elbert H. (7)
Pollack, Roy (2)
Pollard, William E. (11)
Pramuk, Clarence (2)

Q

ACTIVE MEMBERS

Quackenbos, Harrie M. (11)
Quad, Clifford W. (7)
Quaglieri, Charles L. (9)
Quigley, Frederic J. (9)
Quinn, Edward D. (7)
Quinn, John J. (9)
Quinn, Norman J. (1)
Quirk, Martin A. (13)

R

ACTIVE MEMBERS

Raab, Michael (16)
Rachlin, Harry T. (7)
Rachunis, Michael (3)
Racz, George (12)
Rader-Hoheb, Katherine A. (2)
Radest, Louis J. (16)
Rados, Andrew (7)
Raffetto, Joseph F. (13)
Ragany, Joseph (11)
Rainey, Willard G. (11)
Ram, Nathan H. (7)
Rampona, Joseph M. (11)
Rampond, James R. (7)
Ramsey, F. Muriel (6)
Randazzo, Anton P. (16)
Ranson, Briscoe B., Jr. (7)
Rapalski, Adam J. (7)
Rapp, Robert F. (4)
Rappaport, Doris I. (2)
Raso, Frank L. (9)
Rathgeber, Charles F. (7)
Rattenne, Edward (7)
Rauschenbach, Paul E., Jr. (16)
Ravitz, Samuel F. (7)
Rawitz, Sidney B. (7)
Re, Natale M. (2)
Read, Hilton S. (1)
Read, Donald B. (9)
Read, Jessie D. (20)
Read, William T., Jr. (4)
Reading, H. Eugene (16)
Reale, Frank P. (20)
Reale, Nicholas P. (18)
Reason, John J. (12)
Reed, Robert R. (14)
Reeve-Allen, Jane (7)
Reeves, Ernest (16)
Reich, Abraham L. (7)
Reich, Emma (7)
Reich, Henry (7)
Reich, Jerome J. (20)
Reich, Mortimer (7)
Reich, Samuel B. (2)
Reilly, Christopher J. (7)
Reilly, David F. (20)
Reilly, John V. (7)
Reilly, Joseph (4)
Reilly, Thomas F. (16)
Reinartz, Paul V. (7)
Reiner, David N. (16)
Reiner, Jacob (20)
Reinfeld, Abraham G. (7)
Reinhard, Louis (1)
Reinhardt, Warren I. (7)
Reinhold, Herbert E. (2)
Reinhorn, Abraham J. (16)
Reinkraut, Arthur D (16)
Relsinger, Paul B. (11)
Reissman, Erwin (7)
Reiter, Walter A. (20)
Reitman, Norman (12)
Reitnauer, John S. (2)
Relyea, George M. (20)
Remondelli, Raphael E. (7)
Renna, Francis (14)
Renner, Clara C. (18)
Renzulli, Francesco (7)
Repici, Anthony J. (1)
Repta, Stephen (20)
Resch, Henry U. (7)
Restaino, Charles F. (7)
Rettig, Isidor L. (7)
Revere, Seth D. (7)
Reyner, Daniel C. (1)
Reynolds, Donald G. (13)
Reynolds, George G. (13)
Reznikoff, Leon (9)
Rhoads, S. Creadick (8)

Rhone, David S. (4)
Ribbans, Robert C. (7)
Ricciardelli, Emmanuel F. (9)
Riccobono, Cosmo S. (16)
Rice, Franklin W. (14)
Rich, Charles (7)
Rich, Harry H. (7)
Rich, Wallace E. (7)
Richards, Ernest W. (2)
Richardson, Charles A. (2)
Richardson, Marvin T. (7)
Richlan, Alfred (7)
Richlin, Padie (12)
Ricketts, Henry E. (7)
Rieck, Allan (1)
Riegert, Louis C. (4)
Rieman, Aloysius P. (9)
Riese, Jacob A. (9)
Riffin, Irving M. (7)
Rifici, Anthony L. (13)
Riggs, Vincent J. (7)
Riley, Philetus H. (14)
Rineberg, Irving E. (12)
Ringe, Charles L., Jr. (21)
Rinzler, Elliot (7)
Rinzler, Harry G. (16)
Rinzler, Harvey (15)
Ripley, E. Warren (7)
Rise, Wilson S. (1)
Ristine, Edwin R. (4)
Rita, James J. (11)
Ritter, John J. (16)
Rizzolo, Edward M. (7)
Robbin, Lewis (7)
Robbins, Charles M. (7)
Robbins, Eugene (7)
Robbins, Morris A. (3)
Roberts, Allison H. (7)
Roberts, Charles D. (2)
Roberts, David C. (7)
Roberts, Joseph E., Jr. (4)
Roberts, William A. (7)
Robertson, Eugene V. (16)
Robertson, Euston S. (7)
Robertson, Grace M. (20)
Robie, Theodore R. (7)
Robinson, Anne W. (20)
Robinson, Ernest A. (13)
Robinson, Louis H. (7)
Robinson, William A. (13)
Rocco, Frank (7)
Rocco, Leo C. (13)
Rodi, Louis M. (1)
Rodman, E. Warren (3)
Roecker, R. (18)
Roemer, Jacob (16)
Rogers, Dorothy M. (8)
Rogers, James A. (16)
Rogers, Laurence H. (11)
Rogers, Robert H. (7)
Roh, Robert F. (7)
Romano, Anthony M. (2)
Romano, Michael J. (16)
Romano, Patrick J. (7)
Rommer, J. Jay (7)
Rona, Maurice (12)
Rooks, Wendell H. (2)
Roop, William O. (1)
Rosamilia, Ralph E. (7)
Rose, Abraham (20)
Rose, Salvatore J. (7)
Rose, William G. (11)
Roseman, Herman I. (7)
Rosen, Charles D. (7)
Rosen, Charles E. (9)
Rosen, Emanuel (7)
Rosen, Frank L. (7)
Rosen, Herbert J. (14)
Rosen, Sol (6)
Rosenbaum, Samuel X. (7)
Rosenberg, Alvin A. (14)
Rosenberg, Jacob (9)
Rosenberg, L. Charles (7)
Rosenberg, Lillian M. (7)
Rosenberg, Louis (1)
Rosenberg, Max (7)
Rosenblatt, Max B. (20)
Rosenblatt, Sidney (1)
Rosenstein, Jacob L. (9)
Rosenstein, Saivel L. (20)
Rosenthal, Arnold J. (7)
Rosenthal, Oscar J. (7)
Rosenthal, Sydney (7)
Rosner, Edwin (4)
Ross, Ira S. (7)
Ross, Peter W. (16)
Rossi, John R. (9)
Rost, Adolf S. (7)
Roston, Mark A. (7)
Roth, Daniel B. (2)
Roth, Ferdinand L. (7)
Roth, Oswald H. (7)
Rothfuss, C. Howard (12)
Rothgesser, Jerome C. (7)
Rothhouse, Burnet (7)
Rothschild, Daniel L. (7)
Rothschild, Karl (12)
Rothseid, Abraham (7)
Rowan, Henry M. (11)
Rowe, Joseph A. (2)
Rowland, John H. (12)
Rowohlt, George O. (2)
Roy, Bert W. (19)
Roy, Joseph N. (16)
Roylance, F. Dean, Jr. (2)
Rozsa, Stephen (7)
Rozett, Oscar (20)
RuBacky, Joseph F. A. (16)
Rubba, Russel R. (1)
Rube, Joseph A. (2)
Rubens, Otto (14)
Rubenstein, Eli (9)
Rubenstein, Robert (9)
Rubin, Abraham A. (7)
Rubin, Adrian D. (13)
Rubin, David (20)
Rubin, Harold (13)
Rubin, Henry S. (14)
Rubin, William (12)
Rubino, Nicholas M. (7)
Ruccia, Arthur (7)
Rucker, William C. (2)
Rudolph, John P. (4)
Ruffer, Ralph A. (9)
Rullman, Walter A. (13)
Rumage, William T. (7)
Rumsey, William L., Jr. (20)
Rundlett, Emilie V. (9)
Runnells, John E. (20)
Runyan, William J. (7)
Runyon, Laurence P. (12)
Ruocco, William B. (16)
Ruoff, Andrew C. (9)
Ruoff, Andrew C., III (2)
Russell, Charles B. (16)
Russell, Karl S. (4)
Russo, Dominic T. (18)
Russomanno, Raymond L. (7)
Ruttenberg, Max (4)
Ruvane, Joseph J. (9)
Ryley, Harold W. (2)
Ryman, Merlin T. (14)

ASSOCIATE MEMBERS

Raphael, Chester (13)
Rath, Morris (7)
Rathauser, Frank (11)
Resnick, Nathan (11)
Ressetar, Michael (16)
Rhodes, Harry, Jr. (2)
Ritota, Michael C. (7)
Rizzo, Ettore G. (16)
Robinson, Aaron J. (11)
Rocco, John (7)
Romano, Frank (12)
Rosenberg, Norman (12)
Ross, Bernard (2)
Rosso, John D. (11)
Rothman, Sidney (11)
Rubin, Sidney (7)
Rush, Martin R. (13)
Rusin, Michael J. (2)
Russomanno, Paul (7)

S

ACTIVE MEMBERS

Sabarese, Theodore C. (16)
Sabini, Cecil F. (9)
Sacco, Anthony G. (9)
Sacco, Gregory E. (13)
Sachs, Fred (9)
Sachs, Wilbert (9)
Sackin, Stanley (11)
Saco, Louis S. (16)
Sadoff, Joseph (20)
Saffron, Morris H. (16)
Sager, Clifford J. (20)
Sager, Harold (9)

Sagi, Ellen I. (20)
Sakowski, John P. (9)
Sala, Aldo W. (16)
Saladino, Anthony J. (9)
Salaky, William L. (12)
Salasin, Samuel L. (1)
Salmeri, Edward J. (2)
Salmon, Edward F. (9)
Salmon, George G., Jr. (7)
Salsberg, Ralph H. (7)
Salter, Kent (16)
Saltus, Lloyd S. (14)
Salvati, Leo H. (20)
Salvatore, Joseph T. (11)
Salway, Benjamin (11)
Salzman, Nathan (16)
Salzmann, Bertold (9)
Samson, Norman D. (7)
Samuel, Jerome H. (7)
Sand, Abraham B. (3)
Sandella, Joseph F. (12)
Sandler, Moses (2)
Sanfacon, Thomas A. (16)
Sanford, Marcus E. (18)
Santangelo, Emil L. (16)
Santor, Daniel (4)
Santor, G. Frank (4)
Santora, Philip J. (7)
Santosky, Benjamin B. (9)
Saporito, Archibald R. (7)
Saracino, Frank J. (7)
Saradarian, Albert V. (9)
Sarajian, Aram M. (2)
Sargent, Eva R. (18)
Sarla, Michael (2)
Sarokhan, Joseph (16)
Saseen, Charles A. (1)
Saslow, Benjamin I. (7)
Saslow, Stella K. (7)
Satulsky, Emanuel M. (20)
Sauerbrun, Bertram J. L. (20)
Saukimas, John (18)
Saulsberry, Charles E. (12)
Savel, Lewis E. (7)
Sawyer, Blackwell (15)
Sax, Max T. (7)
Sbarra, Francesco C. N. (7)
Scala, H. Albert (9)
Scalessa, Mario F. T. (20)
Scammell, Frank G. (11)
Scanlan, D. Ward (1)
Scasserra, Benedict B. (11)
Scerbo, Ernest (2)
Schaaf, Royal A. (7)
Schaberg, Frank J. (2)
Schaefer, Eugene P. (7)
Schaeffer, Alan M. (3)
Schafer, Marguerite A. (16)
Schaffer, Barney (7)
Schaffer, Nathan (7)
Schall, Reuben E. (4)
Schapiro, Morris (9)
Schectman, Vera (7)
Scheer, Eli (2)
Scheffler, Wilhelm A. H. (4)
Schefrin, Alexander E. (16)
Scheiber, Geza (7)
Schellenger, Edward A. Y. (4)
Scheller, George A. (7)
Schenk, Joseph R. (20)
Schenker, Benjamin N. (9)
Schenker, Israel N. (9)
Schenker, Sarah S. (9)
Schept, Samuel S. (9)
Scher, Maurice A. (7)
Schiffmann, Samuel (7)
Schildkraut, Jacob M. (11)
Schiller, Edwin (20)
Schiller, Rosa O. (20)
Schilling, Anthony B. (20)
Schimenti, Matteo (9)
Schirber, Rene G. (12)
Schiro, S. Robert (2)
Schisler, Milton M. (3)
Schleifer, Arnold (16)
Schlein, August (9)
Schlein, David (20)
Schlichter, Charles H. (20)
Schlossbach, Theodore (13)
Schlossberg, Ezra (16)
Schmidt, Albert F. (13)
Schmidt, Clifford M. (19)
Schmidt, Walter W. (2)
Schmukler, Jacob (7)
Schneckendorf, Samuel J. (9)
Schneider, Charles A. (7)
Schneider, Clinton R. (15)
Schneider, Louis (7)
Schneider, Louis A. (9)
Schoenau, Carl W. (7)
Schotland, Clement E. (7)
Schrack, Helen F. (4)
Schram, William S. (7)
Schramm, Joseph A. (7)
Schreck, Harry (7)
Schretzmann, Rudolph C. (2)
Schubert, Roy R. (16)
Schuchner, William F. (9)
Schuck, Traugott J. (9)
Schulsinger, Samuel (7)
Schulte, Herbert A. (7)
Schults, Anna R. (7)
Schultz, Augustin M. (16)
Schurman, Francis H. C. (7)
Schwartz, Harold (7)
Schwartz, Harold B. (9)
Schwartz, Henry C. (4)
Schwartz, Jacob R. (16)
Schwartz, Leo (16)
Schwartz, Lewis (9)
Schwartz, Mortimer L. (7)
Schwartz, Samuel H. (20)
Schwartz, William (16)
Schwartzberg, Frederick I. (16)
Schwarz, Berthold T. D. (9)
Schwarz, John (9)
Schwarz, Julianna L. (16)
Schwarz, Leopold (5)
Schwarzkopf, George C. (1)
Schweizer, Roman G. (20)
Sciarrillo, Louis F. (9)
Scielzo, Nicholas F. (16)
Sciorsci, Edward F. (9)
Sciorsci, Mario (9)
Scott, Frederick J. (19)
Scott, Frederick W. (12)
Scott, Harold R. (7)
Scott, John J. (9)
Scott, Leonard G. (6)
Scott, Norman M. (7)
Scott, Samuel G. (9)
Scovern, Louis (16)
Scranton, Charles W. (7)
Scribner, Charles H. (16)
Scullion, Arthur A. (2)
Sealey, Henry J. (2)
Seeler, Albert O. (20)
Seely, Roy B. (11)
Segard, Christian P. (2)
Seiberling, Joseph D. (4)
Seidler, Victor B. (7)
Seidman, Edwin A. (7)
Seidman, Joshua I. (7)
Seidmon, Edward E. (20)
Seifert, Edwin A. (7)
Seiler, Benjamin (2)
Seitzick-Robbins, Hannah E. (11)
Sekerak, Albert J. (11)
Sell, Frederick W. (20)
Sellitto, Anthony M. (7)
Sena, Marie A. (7)
Sender, Fannie (12)
Senerchia, Fred F., Jr. (20)
Serri, William S. (8)
Seto, Stanford P. T. (4)
Sevringhaus, Elmer L. (7)
Seward, Frederic H. (14)
Seward, William H. (7)
Sewell, Stephen (13)
Sexton, Edward V. (2)
Seybold, Arthur D. (20)
Seymour, Edward T. (2)
Seymour, George A. (20)
Shack, Maxwell H. (7)
Shaen, Edward (4)
Shafer, Albert H. (4)
Shafer, F. William (4)
Shangle, Milton A. (20)
Shangold, Jack E. (10)
Shanik, Morton J. (14)
Shanik, William (13)
Shannon, James B. (7)
Shannon, Lardner M. (7)
Shapiro, Charles S. (3)
Shapiro, David (16)
Shapiro, Irving (7)
Shapiro, Louis (7)
Shapiro, Louis G. (16)
Shapiro, Max (20)
Shapiro, Ralph N. (7)
Shapiro, Samuel A. (7)
Shapiro, Saul J. (13)
Sharp, Charles E. (6)
Sharp, Reuben L. (4)
Shaul, Frederick G. (7)
Shaul, John F. (7)
Shavelson, Irving C. (1)
Shaw, Ernest B. (4)
Shaw, John J. (7)
Shaw, Ned (7)
Shayevitz, Abraham S. (12)
Sheaffer, Clinton P. (4)
Shear, M. Murray (11)
Shechner, Isadore (7)
Shechtman, Abraham (16)
Sheedy, John J. (20)
Sheehan, Daniel C. (7)
Sheeran, Vincent J. (9)
Sheets, Cecil C. (8)
Sheft, Matthew J. (16)
Shemeley, William G., Jr. (4)
Shenfeld, Isaac (1)
Shepard, Myron (9)
Sheppard, Alfred G. (6)
Sheppard, Muse A. (6)
Sheppard, Thomas S. (6)
Sherk, A. Lincoln (4)
Sherman, A. Russell (7)
Sherman, Abraham (9)
Sherman, Arthur E. (7)

Sherman, Byron G. (14)
Sherman, Elbert S. (7)
Sherman, Fuller G. (8)
Sherman, W. Edgar (12)
Shevitz, David M. (21)
Shill, Benjamin (7)
Shimer, Floyd A. (21)
Shinefeld, Maurice A. (16)
Shipman, James S. (4)
Shipman, Meyer P. (16)
Shipps, Hammell P. (4)
Shirrefs, Russell A. (20)
Shivers, Charles H. deT. (1)
Shlionsky, Herman (7)
Shook, Benjamin E. (9)
Shope, Edward P. (4)
Shor, David M. (7)
Shreehan, Hubert F. (7)
Shull, Elliott C. (4)
Shull, John V. (12)
Shulman, Abraham (16)
Shulman, Murray W. (7)
Shulman, Nathan L. (9)
Shuster, Samuel A. (1)
Sica, L. Samuel (11)
Siciliano, Thomas (16)
Sickel, Emanuel M. (15)
Sieber, Isaac G. (4)
Siegel, Isadore (12)
Siegel, Jack G. (7)
Siegel, Jacob W. (7)
Siegel, Lester (9)
Siegel, Sidney L. (6)
Siegel, Victor (13)
Siemion, Theophilis R. (11)
Sieskind, Richard S. (7)
Silberner, Herbert B. (7)
Silich, Robert L. (9)
Silk, Charles I. (12)
Sill, John B. (11)
Silon, Milton R. (9)
Silver, E. Drew (11)
Silvera, Salomon (9)
Silverman, Irving A. (16)
Silverman, R. Louis (17)
Silverman, S. Andrew (7)
Silverman, Theodore M. (20)
Silvers, Homer I. (1)
Silverstein, Benjamin J. (7)
Silverstein, Jacob M. (7)
Simeone, Peter A. (9)
Simkin, Abraham (16)
Simmons, Albert V. (7)
Simms, George F. (7)
Simon, Fritz C. (10)
Simon, Henry (7)
Simon, Ludwig L. (7)
Simon, Philip H. (16)
Simonson, Louis (7)
Simpson, David B. (9)
Sims, Richard V., Jr. (20)
Sinexon, Henry L. (8)
Singer, Bella (20)
Singer, Marie J. (2)
Singer, Max (7)
Singer, Sina S. (9)
Sinkinson, Charles D., Jr. (1)
Sinnott, Gerald W. (9)
Sisson, Nelson W. (7)
Siwek, Stanley (7)
Skvarla, John A. (2)
Skwirsky, Joseph (7)
Skyer, Joseph (4)
Slack, Clarence J. (11)
Slaff, Florence (16)
Slavin, Paul (7)
Sloan, Samuel L. (16)
Slobodien, Benjamin F. (12)
Slocum, Harry B. (13)
Sly, John L. (20)
Smaine, Enrique delC. (2)
Small, E. Lester (3)
Small, Louis (16)
Smalzried, Elmer W. (7)
Smarzo, Marjorie M. (7)
Smith, Arthur B. R. (9)
Smith, B. Earl (11)
Smith, Bertram H. (4)
Smith, Bryan A. (2)
Smith, Byron J. (7)
Smith, Charles H. (7)
Smith, Christopher A. (7)
Smith, DeWitt H. (11)
Smith, Ellis L. (7)
Smith, Elroy W. (16)
Smith, Frank W. (11)
Smith, Harold W. (7)
Smith, Henry G. (7)
Smith, Herman (21)
Smith, Ivan B. (12)
Smith, J. Meredith (7)
Smith, James D. (4)
Smith, John A. (12)
Smith, John V. (12)
Smith, Joseph A. (12)
Smith, Leon A. (16)
Smith, Leonard H. (7)
Smith, Marcia V. (5)
Smith, Marshall (12)
Smith, Meyer (9)
Smith, Nehemiah E. (2)
Smith, Sidney F. (12)
Smith, Thayer A. (7)
Snagg, William T. (4)
Snape, William J. (4)
Snavely, Earl H. (7)
Snedecor, Spencer T. (2)
Snegireff, Leonid S. (11)
Snook, Lee O., Jr. (7)
Snyder, James A. (5)
Sobel, I. Jerome (16)
Sobin, Julius (7)
Sochacki, Alexander (4)
Sokoloff, Oscar J. (12)
Solk, Arthur G. (7)
Solomon, Harold (7)
Solworth, Lee (2)
Somberg, Harold (7)
Somers, Fred L. (7)
Somers, Williard H. (2)
Sommer, George N. J. (11)
Sommer, George N. J., Jr. (11)
Sordillo, Anthony (20)
Soschin, Samuel J. (7)
Sosnow, Louis M. (2)
Spaldo, John L. (18)
Spallone, Joseph C. (7)
Spano, Frank (9)
Sparks, Paul R. (3)
Spath, Willlam H. (9)
Speer, Charles A. (20)
Spence, Harold G. (7)
Spencer, Alvan (14)
Spencer, Ira T. (12)
Spencer, James H., Jr. (19)
Sperling, Irving L. (7)
Sperling, Walter (7)
Spiegelglass, Abraham B. (2)
Spillane, Timothy H. (21)
Spinner, Samuel L. (7)
Spirito, Michael W. (20)
Spivack, David (20)
Spivack, Seymour E. (20)
Spohn, Eugene L. (9)
Spradley, Jeems B. (11)
Sprague, Edward W. (7)
Sprague, Seth B. (9)
Spranz, William S. (2)
Spritzer, Theodore D. (12)
Spurgeon, Dorsett L. (19)
Stabile, John A. (11)
Staehle, Richard H. (7)
Stage, Earl DeW. (14)
Stahl, Alfred (7)
Stahl, Charles (7)
Staknevich, John H. (7)
Stamps, G. Ruffin (1)
Stanowicz, Stefan J. (21)
Stark, Jacob (16)
Starr, Benjamin (9)
Starr, George R., Jr. (7)
Stassi, Anthony (2)
Statman, Arthur J. (7)
Staub, E. Milton (20)
Stearns, Thornton (7)
Steel, John M. (11)
Steel, William A. (5)
Steele, Stephen (20)
Stefansin, Frank (9)
Steffens, Charles T. (12)
Stein, Albert (9)
Stein, Emil (20)
Stein, Frederick (2)
Stein, George H. (20)
Stein, Harold M. (16)
Stein, Harriet N. (16)
Stein, Isadore (20)
Stein, Jacob M. (9)
Stein, Joseph M. (4)
Stein, Louis A. (11)
Stein, Martin H. (20)
Stein, William (12)
Steinberg, Benjamin L. (16)
Steinberg, Werner (20)
Steiner, Edwin (7)
Steiner, Herbert (7)
Steitz, John A. (3)
Stephenson, Daniel H. (4)
Stephenson, Gordon A. (20)
Stern, Max E. (7)
Stern, Morris H. (16)
Stern, Morton M. (7)
Stetser, Leland M. (4)
Steuart, David F. R. (14)
Stevens, Merton H. (7)
Stevenson, G. McKay (20)
Stevenson, George S. (13)
Stewart, Irving J. (8)
Stewart, Katherine E. (19)
Stewart, Robert G. (7)
Stewart, Sloan G. (1)
Stewart, Walter B. (1)
Stickles, Lloyd C. (7)
Stier, Howard W. (16)
Stiles, C. Campbell (7)
Stockfisch, Robert H. (9)
Stoddard, Gordon V. (7)
Stokes, Anthony T. (9)
Stokes, Donald E. (7)
Stokes, James S. (16)
Stokes, Joseph (3)
Stokes, S. Emlen (3)

Stoll, George F. (7)
Stolow, Alan A. J. (18)
Stoltz, Raymond R. (16)
Stone, Frank P. (4)
Storaci, Frank S. (11)
Stouter, Francis L. (16)
Strack, Vincent J. (7)
Strahan, Frank G. (13)
Straub, Herbert H. (7)
Straus, Frederick W. (4)
Straus, Max (7)
Straus, Walter (11)
Strauss, Arthur (13)
Strauss, Clifton J. (20)
Strauss, Frederick (7)
Strauss, Max (7)
Strauss, William T., Jr. (7)
Streen, Morris E. (7)
Strelinger, Alexander (20)
Strenski, John (3)
Strom, Abraham (20)
Stuart, J. Earle (20)
Stuart, William C. (9)
Sturchio, Edoardo (7)
Sturchio, Eugenio (7)
Stybel, Joseph (20)
Subin, Harry (1)
Sucoff, Moses C. (16)
Suffness, Gustave (20)
Sufrin, Emanuel (4)
Sullivan, Charles J. (12)
Sullivan, William M., Jr. (16)
Summerill, Garnett (4)
Summers, Alfred D. (11)
Summey, Thomas J. (3)
Surgent, George W. (16)
Surran, Carl A. (1)
Sussman, Harold (9)
Suter, Harry F. (17)
Sutherland, William W. (16)
Sutnick, Theodore B. (11)
Sutton, Joseph G. (7)
Swain, Richard D., Jr. (7)
Swern, Nathan (11)
Swertfeger, Herbert W. (11)
Swiecicki, Martin E. (4)
Swiney, Merrill A., III (9)
Symes, Earl R. (7)
Szerlip, Leopold (7)
Szivos, Louis A. (7)
Szold, Norman F. (15)
Szuch, Nicholas (12)
Szymanski, John J. (16)

ASSOCIATE MEMBERS

Salasin, Robert G. (1)
Salerno, Louis (16)
Sandford, Francis R. (7)
Santangelo, Joseph A. (7)
Santoro, Anthony (16)
Sarno, Anthony (7)
Scalera, John F. (12)
Schaaf, Royal S. (7)
Schmaier, Sica L. (13)
Schmidt, J. Ross (1)
Schneider, Leonard (13)
Schnur, Bernard (11)
Schwartzfeld, Hyman (7)
Scialli, Vincent A. (2)
Scudese, Vincent A. (7)
Seidel, Reginald (2)
Selikoff, Irving (16)
Shapiro, Joseph S. (16)
Shapiro, Sydney H. (7)
Sharlin, Herbert S. (7)
Siegel, Leo (7)
Siegel, Ralph E. (12)
Silber, Irving M. (12)
Silver, Michael W. (16)
Silverman, Mendel (2)
Sinderbrand, Robert E. (1)
Siss, Alfred A. (16)
Sklar, S. Harvey (2)
Smith, Alan L. (7)
Smith, Percy L. (11)
Snell, Philip (16)
Sobol, Herman (7)
Sollami, William R. (11)
Sparks, Spurgeon, Jr. (7)
Sperber, Thomas J. (2)
Spinnler, Henry R. (16)
Sporer, Andrew (16)
Steller, Frederick C. (13)
Stollman, Bernard D. (12)
Strazza, John A. (7)
Sullivan, James M., III (11)
Susinno, Anthony M. (2)
Svenson, Sven E. (7)

T

ACTIVE MEMBERS

Taber, Frederick S. (12)
Taber, Leslie R. (16)
Taff, Harry (7)
Taffet, William (7)
Taft, Herman L. (9)
Talmage, William G. (14)
Talty, John C. (9)
Tannert, Carl H. (9)
Tansey, W. Austin, Jr. (7)
Tarbell, Harold A. (7)
Targan, Nathan (1)
Tarta, Ciro S. (16)
Tataryan, Hovsep (9)
Tatem, Henry R., Jr. (4)
Tator, Arthur E. (20)
Taylor, Harold W. (2)
Taylor, Raymond A. (15)
Teeter, Charles E. (7)
Teichholz, Max H. (16)
Tell, M. Edward (16)
Teller, Daniel W., Jr. (14)
Temes, J. Howard (9)
Tenney, Albert S. (7)
Tenney, Luman H. (11)
Tennis, Edgar M. (2)
terKuile, Reinold W. (2)
Terrell, Edward E. (20)
Terreri, D. Joseph (14)
Terwedow, Henry (9)
Terwedow, Walter G. (9)
Tether, Russell K. (2)
Thalheimer, Edward J. (6)
Thomas, Claude W. (17)
Thomas, George N. (6)
Thomas, Harry G. (13)
Thomas, Irene O. (16)
Thomas, John H. (7)
Thomas, Leon H. S. (16)
Thomas, Ralph B. (9)
Thomas, Thomas S., Jr. (14)
Thomison, Harry E. (7)
Thompson, Arthur F. (7)
Thompson, Edward C. (16)
Thompson, Minturn R. (20)
Thompson, Penrose H. (4)
Thompson-Bohne, Mildred H. (20)
Thomson, Carroll S. (7)
Thorne, Nathan (3)
Thorne, William P. (16)
Thornhill, Arthur C. (7)
Thornley, William F. (7)
Thron, Leopold E. (16)
Thum, Kurt W. (7)
Tidaback, John D. (20)
Tidwell, Harold F. (9)
Tillis, Herman H. (7)
Timberlake, Baxter H. (1)
Timlin, James W. (9)
Tisch, Leon (12)
Toal, Joseph (2)
Tobey, Franklin J. (7)
Tobey, John R. (7)
Tocci, Frank (7)
Toczek, Heinrich A. (7)
Todd, Francis H. (16)
Tolomeo, Martin E. (18)
Tolor, Stanley (20)
Tomec, Otto C. (11)
Tomec, Richard F. (7)
Tomkins, William (16)
Tomlins, Francis I. (2)
Tomlinson, Rolland D. (20)
Tompkins, Grenelle B. (10)
Torppey, John J. (7)
Toscano, George A. (2)
Towbin, Adolph (15)
Townsend, John B. (5)
Townsend, Leslie M. (20)
Toy, Calvert R. (12)
Tracy, George T. (3)
Traganza, Robert W. (4)
Trano, Giovanni (20)
Trautwein, Charles F. (7)
Treiber, Benjamin A. (11)
Tretter, Hans L. (11)
Triarsi, Anthony J. (20)
Trippe, Clarence M. (13)
Trippe, Morton F. (13)
Troedsson, Bror S. (7)

Troum, Nathan (9)
Truax, Alfred J. (14)
Tsucalas, James C. (9)
Tucker, Albert B. (7)
Tucker, Sidney (12)
Tuly, Ralph (7)
Tunis, Benno B. (7)
Turi, Amedeo E. (7)
Turner, Charles F. (7)
Turner, Isabel B. (2)
Tushnet, Leonard (7)
Tutela, Arthur C. (7)
Tweddel, George K. (16)
Twitchell, Adelbert B. (7)
Tymeson, Walter R. (7)
Tyndall, Alice E. (20)
Tyndall, Hugh H. (9)
Tyndall, Martha W. (20)
Tyrrell, George W. (12)
Tyson, Frances B. (2)

ASSOCIATE MEMBERS

Taffet, Seymour (7)
Taterka, Adrian (7)
Taylor, Earl S. (11)
Taylor, John H. (11)
Thompson, Victor (13)
Thurm, Arthur S. (11)
Travers, Frank A. (7)
Turner, Rodney C. (11)

U

ACTIVE MEMBERS

Udinsky, Hyman J. (16)
Uhr, Jacques S. (12)
Ulan, Jerome (12)
Ulan, Oscar (7)
Ulmer, Chester I. (8)
Ulmer, D. H. Bartine (3)
Ulvestad, Lawrence E. (7)
Underwood, J. Harris (8)
Upham, Helen F. (13)
Urbach, George (7)
Urbaniak, Henry S. (11)
Urbanski, Matthew F. (12)
Urevitz, Abraham (9)
Utens, Max (2)
Utkewicz, Edmond A. (9)
Uzzell, Edward F. (1)

V

ACTIVE MEMBERS

Vaczi, Stephen (11)
Valentin, Irmgard (7)
Vallario, Frank A. (7)
Vandenberg, Werner (1)
Vanderbeck, James J. (16)
Vanderbeek, Andrew B. (16)
Vanderbeek, Frank B. (16)
Vanderbeek, Stuart W. (2)
Vander Clock, Cornelius (16)
Vander Veer, H. Garrett (7)
Van Dyke, Joseph S. (2)
Van Eerde, Albert (16)
Van Emburgh, George H. (7)
Van Gieson, Edward J. (7)
Van Mater, John S. (12)
Vann, Dorothea D. (2)
Vann, Felix H. (2)
Vannatta, George W. (7)
Vanneman, Joseph S. (11)
Van Ness, H. Roy (7)
Van Schott, Gerard J., Jr. (16)
Van Wiemokly, Seymour S. (14)
Van Winkle, Charles I. (2)
Van Winkle, John S. (16)
Vargyas, Joseph C. (12)
Varney, William H. (21)
Varriano, John L. (9)
Vento, Sebastian J. (11)
Venturo, Ralph C. (8)
Verbeck, George B. (7)
Verdon, Robert E. (2)
Vermes, Leslie (19)
Vermeulen, Abram (16)
Vernaglia, Anthony P. (16)
Vespignani, Pasquale (9)
Villanova, Ralph N. (7)
Villapiano, Joseph G. (13)
Vincent, Nicholas F. (7)
Vinciguerra, Michael (20)
Virgilio, Anthony A. (7)
Visceglia, Frank R. (9)
Visconti, Joseph A. (9)
Vita, Frank J. (2)
Vitale, Dominic V. (20)
Viteri, Luis E. (3)
Viti, Henry A. (9)
Vogel, H. Austin (20)
Volpe, Donald J. (1)
Vol-Tretter, Marta (11)
von Deilen, Henry O. (14)
Von Hofe, Frederick H. (7)
Von Oehsen, William H. (7)
Voorhies, William S., Jr. (14)
Voorhis, Charles F. (3)
Vosburgh, Fred (16)
Voss, J. Landon (14)
Voss, John C. (3)
Vostrosablin, Nicholas A. (9)
Vreeland, Ralph J. (16)
Vroom, William L. (2)

ASSOCIATE MEMBERS

VanAmberg, Robert J. (7)
Vargish, Hildegard S. (2)
Vargish, Jacob (2)
Varhol, Joseph G. (16)
Verga, Armand (13)
Vernon, Leonard J. (7)
Vine, Blair (11)
Vogel, Nathan F. (2)

W

ACTIVE MEMBERS

Wacker, William F. (20)
Wade, Simon F. (20)
Wager, Henry P. (9)
Wagner, J. George (3)
Wagner, John (7)
Wagner, Richard (20)
Wainright, Melvin A. R. (13)
Wakeley, William E. (7)
Waldron, Robert E. (7)
Walkenberg, Michael (7)
Walker, Ada H. (6)
Walker, Harold G. (16)
Walker, H. Burton (6)
Walker, Levi M. (1)
Walker, Robert B. (12)
Wallace, Marc J. (16)
Wallack, Charles A. (7)
Wallack, Eli A. (9)
Walsh, Charles R. (7)
Walsh, Ronald J. (20)
Walsh, Thomas J. (20)
Walters, George M. (12)
Walton, Gordon G. (16)
Walton, Ralph W. (7)
Wambsganss, Magdalena (7)
Wandall, Frederick G. (8)
Wangner, William F. (7)
Wantoch, Joseph (12)
Warburton, Jack C. (16)
Ward, Albert H. (16)
Ward, Albert J. (14)
Ward, Chauncey P. (7)
Ward, Elisabeth B. (7)
Ward, Gertrude P. (7)
Ward, Leo J. (20)
Ward, Mary (2)
Ward, William R. (7)
Ward, William R., Jr. (7)
Ware, Carl N. (6)
Warne, Merna M. (14)
Warner, Halsey F. (7)
Warner, William H. A. (7)
Warren, Charles B. (2)
Warren, David E. (16)
Warren, Earl L. (16)
Warren, Jacob (16)
Warter, Peter J. (11)
Warwick, Ralph A. (4)
Wassing, Hans (16)
Waterman, Samuel M. (7)
Waters, Charles H. (11)
Waters, Edward G. (9)
Watman, Anthony J. (9)
Watov, Samuel E. (11)
Watson, Frederick S. (11)
Watts, Wilbur (11)
Waugh, Bascom S. (4)
Way, Clarence W. (5)
Wayman, Bernard R. (11)
Webb, Eleanor A. (20)
Webb, Wilson D. (2)
Weber, Francis C. (7)
Weber, John F. (12)
Weber, Laura E. (9)
Weber, Walter D. (9)
Weeks, Belford A. (1)
Weeks, Norman E. (7)
Weems, Don B. (8)
Wegryn, Louis S. (20)
Weigel, Edgar W. (20)
Weigel, Elmer P. (20)
Weigert, Wolfgang U. (4)
Weimann, Max L. (4)
Weiner, Henry T. (12)
Weiner, Samuel E. (1)
Weinert, Henry V. (16)
Weinmann, Max H. (7)
Weinstein, Francis S. (7)
Weinstein, Leopold (7)
Weinstein, Morris W. (7)
Weinstein, Robert A. (19)
Weintraub, William L. (16)
Weiser, Edward H. (19)
Weisman, Herbert (9)
Weisman, Stephen L. (16)
Weiss, Abram (2)
Weiss, Herman (14)
Weiss, Louis (7)
Weiss, Morris J. (9)
Weiss, Mortimer H. (7)
Weiss, Samuel A. (2)
Weiss, Selma (7)
Weissberg, William W. (20)
Weissman, Meyer T. (20)
Weitz, Abraham (20)
Weitz, Paul (18)
Welkind, Allen A. (7)
Weller, Arthur (7)
Wells, William C. V. (3)
Weltchek, Herbert (20)
Wender, Harold (18)
Wentz, Irl Z. (15)
Wentzell, J. Earl (8)
Wescoat, George N. A. (3)
Wesson, Harrison R. (7)
West, David H. (4)
West, Guernsey F. (21)
Westerhoff, Peter D. (16)
Westney, F. Rolfe (1)
Weston, Clifford G. (7)
Wetherhold, John M. (17)
Wetterberg, Louis F. (12)
Whaland, Berta (6)
Whalen, Edward C. (4)
Wheatland, Marcus F., Jr. (4)
Wheeler, James A. V. (9)
Wheeler, William K. (7)
Whelan, Edward P. (7)
Whims, Clarence B. (1)
Whitaker, Henry J. (8)
Whitaker, John C. (3)
White, Frank S. (2)
White, Harry J. (12)
White, Hugh M. (9)
White, R. Rostin (1)
White, Richard E. (16)
White, Robert R. (7)
White, Thomas J. (9)
Whiticar, John H. (5)
Whitken, Albert I. (20)
Whitman, Lloyd B. (2)
Whittaker, Neil S. (2)
Wiant, Herman E. (4)
Wichman, Heins (9)
Widetsky, Alfred (2)
Wiener, David (7)
Wiesenfeld, Benjamin (12)
Wiesler, Howard M. (11)
Wiggins, Ulysses S. (4)
Wikoff, John L. (11)
Wilbur, Franklin L. (13)
Wilcox, Frank A. (9)
Wildman, Edward D. (3)
Wilentz, William C. (12)
Wilkins, Stanley O. (13)
Willan, Edward H. (7)
Willetts, Arthur T. (20)
Willey, F. Parker (7)
Willey, Harry S., Jr. (13)
Williams, David P. (14)
Williams, Edith B. (2)
Williams, Frank A. (20)
Williams, Harry D. (11)
Williams, Hiram (16)
Williams, John J. (7)
Williams, Leonard D. (20)
Williams, Louis E. (14)
Williams, Manley C. (20)
Williams, Raymond A. (1)
Williams, William C. (2)
Williams, William C. (4)
Willner, Albert (7)
Willner, Irving (7)
Willner, Milton (7)
Willner, Philip (7)
Willson, James H. (7)
Wilner, Arthur S. (11)
Wilner, Irving (11)
Wilson, Charles W. (6)
Wilson, Harrison B. (2)
Wilson, Herbert H. (6)
Wilson, Isan E. (4)
Wilson, John H., Jr. (7)
Wilson, Lawrence A. (1)
Wilson, Lester R. (4)
Wilson, Robert B. (13)
Winn, Samuel L. (1)
Winslow, John H. (6)
Winter, Carl M. (4)
Winter, Egon W. (7)
Winter, Gladys C. (2)
Winters, Walter M. (16)
Wishnack, Meyer (16)
Witkoff, Ben. (2)
Witkowski, Joseph L. (4)
Witmer, John D. (12)
Witte, C. Norman (15)
Wittenborn, William F. J. (11)
Woelfle, Henry E. (9)
Wolbert, Charles M. (9)
Wolf, Erich (16)
Wolf, Frank A. (21)
Wolf, Israel J. (16)
Wolf, Raymond E. (7)
Wolfe, Edward E. (2)
Wolfe, Jacob S. (7)
Wolfe, William W. (7)
Wolff, Herbert M. (11)
Wolff, Jerome M. (20)
Wolfsle, Jacob H. (18)
Wolfson, Harry (16)
Wolgin, Philip L. (20)
Wolowitz, Harry B. (2)
Wood, E. LeRoy (7)
Woodman, Charles B. (14)
Woodruff, Dare (6)
Woodruff, Ralph G. (13)

Woody, McIver (20)
Woolf, Bernhardt H. (7)
Worcester, George F. (2)
Work, John L. (7)
Wort, Frederick J. (7)
Worthington, Joseph A. (13)
Wortman, Herbert M. (7)
Wrensch, Alexander E. (7)
Wright, Herman W. (8)
Wright, Ralph S. (4)
Wright, Robert E. (7)
Wroblewski, Benjamin M. (4)
Wry, Dean A. (16)
Wry, Orlin V. (2)
Wuerthele, Virginia E. (7)
Wuester, William O. (20)
Wujciak, Henry J. (7)
Wurts, Margaret M. (7)
Wurzel, Milton (7)
Wyatt, Joseph H. (7)
Wyker, Arthur W. (7)
Wyman, Edward H. (3)
Wynder, Alfred (7)

ASSOCIATE MEMBERS

Wakeley, William E., Jr. (7)
Waldron, John F. (7)
Walker, Nelson C. (2)
Walker, Otto (12)
Wannamacher, Paul (7)
Warnecke, Rudolph E. (7)
Weinberg, C. Richard (7)
Weiner, Aaron (16)
Weintrob, Joseph R. (1)
Weiss, Fred (7)
Whelan, Vincent (13)
Whigham, Herbert H. (7)
Wiesenfeld, Paul (12)
Winder, Miles S., Jr. (13)
Winfield, Irwin (12)
Winn, James S. (12)
Winn, William M. (12)
Witman, H. John, Jr. (11)
Wollack, Alfred (2)
Woolbert, Edwin (1)
Wortman, Harry C., Jr. (7)
Wren, James C. (2)

Y

ACTIVE MEMBERS

Yablonsky, Max (7)
Yachnin, Samuel C. (16)
Yadkowsky, Emanuel (7)
Yaeger, Leslie A. (11)
Yager, J. Allen (16)
Yaguda, Asher (7)
Yankowicz, Michael (7)
Yanowitz, Bernard (9)
Yarnell, Helen (20)
Yasskin, Hymen E. (4)
Yates, Glen L. (7)
Yates, John S. (16)
Yeaton, William L., Jr. (9)
Yeaw, Ralph C. (16)
Yelin, Gabriel (7)
Yellin, Charles H. (20)
Yingling, Paul L. (5)
Yolken, Harry (16)
Yontef, Reuben (9)
Yood, Harold S. (20)
York, Jack S. (7)
York, James L. (2)
York, Wilbur H. (11)
Yorke, Benjamin (16)
Yorke, Edward T. (20)
Young, Franklin C. (20)
Young, George J. (14)
Young, I. Henry (7)
Young, James L. (18)
Young, John H. (7)
Young, Ralph A. (20)
Yuckman, Robert O. (20)
Yudkoff, William (9)
Yurevich, Antony (15)

Z

ACTIVE MEMBERS

Zacher, Andrew A. (7)
Zager, Saul (7)
Zahn, Jack R. (8)
Zalewski, Irene J. (16)
Zampella, Arthur (9)
Zappala, John (17)
Zbar, Joseph E. (9)
Zehnder, A. Charles (7)
Zeitlin, Herman H. (20)
Ziccardi, Anthony V. (3)
Zick, Clara U. (16)
Zimmer, William (7)
Zimmerman, Coler (7)
Zimmerman, Robert F. (14)
Zimskind, Joshua N. (11)
Zingales, Joseph A. (20)
Zingali, John A. (7)
Zirpolo, Gene A. V. (20)
Zitani, Alfred M. (9)
Zuck, Arthur C. (21)
Zucker, Isadore (7)
Zuckerberg, H. Irving (9)
Zuckerman, David E. (16)
Zukerberg, Nathan (7)
Zuloff, D. Blair (14)
Zvaifler, Nathan (7)
Zweibel, Leonard (7)
Zybulewski, Edmund A. (7)
Zweigel, Isidore (7)

ASSOCIATE MEMBERS

Zigarelli, Joseph F. (16)
Zuckerman, Louis (16)

MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising

THE MEDICAL SOCIETY OF NEW JERSEY

ON MARCH 1, 1947

ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets second Friday evening monthly, except in June, July and August. Annual Meeting in May.

ACTIVE MEMBERS

Allman, David B., 104 St. Charles pl., Atlantic City
Andrews, Clarence L., 1616 Pacific av., Atlantic City
Axilrod, Maurice H., 2620 Pacific av., Atlantic City
Bartlett, Clara K., 4301 Atlantic av., Atlantic City
Bassett, Norman H., 1616 Pacific av., Atlantic City
Bayer, Harold J., 1616 Pacific av., Atlantic City
Beir, Ily R., 3900 Atlantic av., Atlantic City
Bew, Richard C., 1217 Pacific av., Atlantic City
Bradley, Robert A., 1616 Pacific av., Atlantic City
Brown, J. Carlisle, 101 S. Indiana av., Atlantic City
Chalfant, W. Paxson, Jr., Army
Charlton, C. Coulter, 1616 Pacific av., Atlantic City
Clark, S. Worth, 152 S. No. Carolina av., AtlanticC'y
Cleary, Joseph P., Minotola
Corson, Filbert R., 101 S. Indiana av., Atlantic City
Crane, Bernard, 306 Pacific av., Atlantic City
Cutler, Milton, 554 Bellevue av., Hammonton
Dalton, S. Eugene, 101 S. Surrey av., Ventnor
Davidson, Harold S., 117 S. Illinois av., Atlantic City
deHellebranth, Roland T., 104 S. Fr'nkf't av.,Ventn'r
Dein, Harry, 1616 Pacific av., Atlantic City
DiNicolantonio, Vincent J., 3121 Atlantic av., Atl. C'y
Donnelly, William A., Navy
Durham, Robert B., 3 S. Oxford av., Ventnor
Durham, Royal E., 100 S. New Haven av., Ventnor
Dyer, Edward H., 102 S. Victoria av., Ventnor
Eckert, Walter L., 809 Stenton pl., Ocean City
Erber, Leonard B., 2 N. Dover av., Atlantic City
Ernst, Philip A., 16 E. Main st., Mays Landing
Esposito, Antonio L., 31 12th st., Hammonton
Ewens, Arthur E., 3600 Pacific av., Atlantic City
Feinstein, Louis, 410 Pacific av., Atlantic City
Fowler, Richard M., Jr., 112 N. Indiana av., Atl.City
Fox, Wm. W., 101 S. Indiana av., Atlantic City
Frank, Myrtile, 227 Philadelphia av., Egg Harbor
Frank, Perry, 227 Philadelphia av., Egg Harbor
Goldstein, Samuel, 34 E. Main st., Mays Landing
Gordon, Benjamin L., 1616 Pacific av., Atlantic City
Gordon, Maurice B., 6917 Atlantic av., Ventnor
Gorson, Samuel F., 2005 Pacific av., Atlantic City
Gottlieb, Morris, President Hotel, Atlantic City
Grier, Robt. M., 50 E. Washington av., Pleasantville
Gross, Max, 7401 Atlantic av., Margate City
Gruhler, Jean A., 125 N. Roxborough av., Ventnor
Gulon, Edward, Atlantic Co. Hosp., Northfield
Halpern, Samuel, 7405 Ventnor av., Ventnor
Harley, Halvor L., 101 S. Indiana av., Atlantic City
Harris, William O., 32 N. New Jersey av., Atl. City
Hersohn, William W., 20 S. Eiberon av., Atl. City
Hess, L. Elmore, 19 E. Bolton av., Absecon
Hoffman, Harry S., 3302 Pacific av., Atlantic City
Holmes, H. David, 15 N. Indiana av., Atlantic City
Holoman, M. Browne, 1 N. Haverford av., Margate
Hughes, James W., Jr., 1903 Pacific av., Atlantic C'y
Hyman, Charles, 2807 Pacific av., Atlantic City
Infield, Gerald L., 1319 Shore rd., Northfield
Irvin, John S., 1910 Pacific av., Atlantic City
Jacobson, J. Joseph, 1616 Pacific av., Atlantic City
Johnson, V. Earl, 101 S. Indiana av., Atlantic City
Kahn, Leo, 32 States av., Atlantic City
Kaighn, Chas. B., 101 S. Indiana av., Atlantic City
Kline, Herman, 2643 Pacific av., Atlantic City
Konzelmann, Frank W., 304 S. Shore rd., Absecon
Krechmer, Abraham, 400 Pacific av., Atlantic City
Lawther, Boyd M., 1401 Shore rd., Northfield
Leonard, Isaac E., 2842 Atlantic av., Atlantic City
Leonard, Isaac E., Jr., 2842 Atlantic av., AtlanticC'y
Lippman, Nathan L., 504 Pacific av., Atlantic City
Lucas, Stanley L., 44 N. Kentucky av., Atlantic City
Magill, Marcus, 4116 Ventnor av., Atlantic City
Major, Morton M., 4212 Ventnor av., Atlantic City
Marshall, H. Donald, 707 N. Indiana av., AtlanticC'y
Marvel, Peter H., 2216 Shore rd., Northfield
Marvel, Philip, Jr., 101 S. Indiana av., Atlantic City
Mason, James H., 1616 Pacific av., Atlantic City
McCracken, Josiah C., Jr., 16 S. Suffolk av., Ventnor
McGeehan, Stanley M., 6505 Atlantic av., Ventnor
Merendino, Anthony G., 2720 Pacific av., AtlanticC'y
MeVay, James C. F., 2907 Pacific av., Atlantic City
Milano, Cesare A., 1 S. Brighton av., Atlantic City
Mishler, Jay E., 1616 Pacific av., Atlantic City
Molitch, Matthew, 705 Pacific av., Atlantic City
Murray, Clifford K., 5901 Ventnor av., Ventnor
Nickman, E. Harrison, 1616 Pacific av., Atlantic C'y
Pennington, John, 101 S. Indiana av., Atlantic City
Perez, John F., 3403 Pacific av., Atlantic City
Petinga, Thomas J., 114 S. Illinois av., Atlantic City
Pilkington, Albert, 117 S. Virginia av., Atlantic City
Poland, Geo. A., 206 E. Verona av., Pleasantville
Powell, Robert J., 410 N. Ohio av., Atlantic City
Quinn, Norman J., 3303 Pacific av., Atlantic City
Read, Hilton S., 5407 Atlantic av., Ventnor
Reinhard, Louis, 2627 Pacific av., Atlantic City
Repici, Anthony J., 107 N. Third st., Hammonton
Reyner, Daniel C., 2703 Pacific av., Atlantic City
Rieck, Allan, 507 S. Shore rd., Pleasantville
Rise, Wilson S., Army
Rodi, Louis M., 412 Bellevue av., Hammonton
Roop, William O., 101 S. Indiana av., Atlantic City
Rosenberg, Louis, 1616 Pacific av., Atlantic City
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City
Rubba, Russell R., 21 Horton st., Hammonton
Salasin, Samuel L., 511 Pacific av., Atlantic City
Saseen, Charles A., 60 S. Delancey pl., Atlantic City
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
Schwarzkopf, George C., 2901 Pacific av., AtlanticC'y
Shavelson, Irving C., 1616 Pacific av., Atlantic City
Shenfeld, Isaac, 4806 Atlantic av., Ventnor
Shivers, Chas. H. deT., 121 S. Illinois av., Atl. City

Shuster, Samuel A., 405 Pacific av., Atlantic City
Silvers, Homer I., 16 S. Suffolk av., Ventnor
Sinkinson, Chas. D., Jr., 1616 Pacific av., AtlanticC'y
Stamps, G. Ruffin, 300 E. Verona av., Pleasantville
Stewart, Sloan G., 43 S. North Carolina av., Atl. City
Stewart, Walter B., 8 N. Tallahassee av., Atl. City
Subin, Harry, 2 S. Somerset av., Ventnor
Surran, Carl A., 1616 Pacific av., Atlantic City
Targan, Nathan, 27 N. Connecticut av., Atlantic City
Timberlake, Baxter H., 5414 Ventnor av., Ventnor
Uzzell, Edward F., 2703 Pacific av., Atlantic City
Vandenberg, Werner, 7 S. La Clede pl., Atlantic City
Volpe, Donald J., Navy
Walker, Levi M., 5407 Atlantic av., Ventnor
Weeks, Belford A., 18 W. Summit av., Absecon
Weiner, Samuel E., 904 Pacific av., Atlantic City
Westney, F. Rolfe, 1920 Pacific av., Atlantic City
Whims, Clarence B., 5407 Atlantic av., Ventnor
White, R. Rostin, 644 Shore rd., Somers Point
Williams, Raymond A., 7207 Atlantic av., Ventnor
Wilson, Lawrence A., 114 N. Shore rd., Absecon
Winn, Samuel L., 1616 Pacific av., Atlantic City

ASSOCIATE MEMBERS

Allar, Ellis H., 115 St. Charles pl., Atlantic City
Baldwin, Charles H., 2829 Atlantic av., Atlantic City
Dierwechter, Reuben, 12 N. Providence av., Atl. City
Green, Martin, 2643 Pacific av., Atlantic City
Harley, Robinson D., 101 S. Indiana av., Atlantic C'y
Kaman, Samuel L., 1616 Pacific av., Atlantic City
Malis, Leonard I., 705 Pacific av., Atlantic City
McGahn, Joseph, Army
Naame, John M., 19 N. Dorset av., Ventnor
Paul, Abraham, 4901 Atlantic av., Atlantic City
Salasin, Robert G., Army
Schmidt, J. Ross, 2216 Shore rd., Northfield
Sinderbrand, Robert E., 344 Phila. av., Egg Harbor
Weintrob, Joseph R., 1616 Pacific av., Atlantic City
Woolbert, Edwin, 15 W. Washington av., Pleasantv le

COURTESY MEMBER

Starkes, Carlton C., Linwood

HONORARY MEMBERS

Carrington, William J., Clinton, Iowa
Marcus, Joseph H., Los Angeles, Calif.
Martin, William, Haddonfield

BERGEN COUNTY (2)

Society organized February 28, 1854 . Meets on second Tuesday of each month, except July and August. Annual Meeting in May.

ACTIVE MEMBERS

Abbott, Charles C., 32 Main st., Lodi
Abramo, Anthony E., 141 Glen av., Midland Park
Agayoff, John D., 127 S. Washington av., Bergenf'd
Alexander, Samuel, 12 S. Main st., Park Ridge
Alexander, Stewart F., 12 S. Main st., Park Ridge
Anderson, Ethelyn J. C., 195 Euclid av., Ridgef'd Pk.
Anderson, Reuben M., 15 Anderson st., Hackensack
Angioletti, Louis V., 1617 Palisade av., Fort Lee
Appold, George D., 60 E. Church st., Bergenfield
Baketel, H. Sheridan, 155 Van Wagenen av., Jer. C'y
Baldwin, John F., 1474 Windsor rd., W. Englewood
Balze, Henry R., 147 Christie st., Leonia
Banta, Raymond E., 201 E. Ridgewood av., Ridgew'd
Barbash, Roslyn H. W., 835 Red rd., Teaneck
Barlow, G. Barton, 157 Engle st., Englewood
Barnes, William J., 155 Engle st., Englewood
Baron, Herbert A., 150 Terrace av., Hasbrouck Hts.
Basralian, Joseph B., 333 Wash'gt'n pl., Hasbr'k Hts.
Bayer, Eric C., 307 E. Madison av., Dumont
Beres, Albert J., 492 Wood-Ridge av., Wood-Ridge
Berke, Raynold N., 430 Union st., Hackensack
Bernard, Richard C., Army
Beyer, William, 612 Undercliff av., Edgewater
Black, LeRoy W., 33 W. Passaic av., Rutherford
Blauvelt-Wells, Grace B., 76 Heights rd., Ridgew'd
Bleasby, Charles B., 136 Passaic st., Garfield
Blenkle, Victor A., 140 Chadwick rd., Teaneck
Bonanno, Peter J., 216 Engle st., Englewood
Bookstaver, Barnet S., 241 Cedar lane, Teaneck
Bosch, Taeke, 290 E. Franklin Turnpike, Hohokus
Branon, Mark E., 16 W. Passaic av., Rutherford
Bregman, Alexander, 2 Dempsey av., Edgewater
Brennan, Alfred T. V. Jr., 275 Engle st., Englewood
Brennan, Ralph J., 301 Plaza rd., Fair Lawn
Brown, John L., 1019 Cumbermede rd., Palisade
Brozyna, Mieczyslaw, 194 Carlton av., E. Rutherf'd
Bump, Samuel C., 505 E. Ridgewood av., Ridgewood
Burnham, Lyman, 229 Engle st., Englewood
Burns, Geoffrey C. H., County rd., Demarest
Burokus, William, 21 E. Pleasant av., Maywood
Busicco, Philip S., 131 Liberty rd., Englewood
Calabrese, Dino, 201 Main st., Fort Lee
Caldwell, George W., 81 E. Clinton av., Tenafly
Campbell, James M., 101 S. Central av., Ramsey
Candio, Vincent P., 366 Ridge rd., Lyndhurst
Carbone, Ralph, 2431 Lemoine av., Coytesville
Carroll, Thomas R., 754 Anderson av., Grantwood
Cartnick, Louis C., 228 Hillcrest av., Wood-Ridge
Caruso, Paul F., 194 Montross av., Rutherford
Catania, Joseph P., 140 Passaic st., Garfield
Catapano, John, 41 Winant av., Ridgefield Park
Chase, Kalman, Jr., 80 Sheridan av., Hohokus
Christensen, Osborne D., 345 Summit av., Hackens'k
Clarie, D'Arcy C., 558 Broad av., Ridgefield
Clark, Margaret A., Glen rd., Woodcliffe Lake
Cloud, Albert W., 139 Hugenot av., Englewood
Connor, Clarence A., 1586 Center av., Fort Lee
Cooper, Howard M., 37 Ridge rd., Rutherford
Coppoletta, Joseph M., 788 Kinderkam'k rd.,Riv.Ed.

Corn, David, 119 Park st., Ridgefield Park
Costabile, Vincent, 324 Second av., Lyndhurst
Crandall, John K., 200 Main st., Fort Lee
Cropsey, Charles D., 168 Chestnut st., Rutherford
Curtis, Donald A., 241 Union st., Hackensack
D'Agostin, Henry, 243 Fulton ter., Cliffside Park
Daly, John F., 877 Queen Anne rd., Teaneck
D'Amato, Charles R., 324 Hoboken rd., E. Rutherford
Davis, Harold, 170 S. Washington av., Bergenfield
Dayton, Spencer T., 86 W. Demarest av., Englewood
DeBiasco, Cornelius V., 9 W. Park pl., Rutherford
DeCecio, Thomas, 691 Palisade av., Cliffside Park
Demarest, J. Willis, 124 Elm av., Hackensack
DeSanto, A. M., Summit av. and Essex st., Hackens'k
Deuell, William D., 190 Elm av., Hackensack
Dezer, Charles N. Jr., 210 Main st., Hackensack
Dickson, John D., 202 Larch av., Bogota
Dilger, Frederick G., 210 Main st., Hackensack
Doyle, George F., 80 Glenwood rd., Englewood
Edgerly, Sherburn E., 185 E. Palisade av., Englew'd
Edwards, J. Bennett, 144 Woodridge pl., Leonia
Ehrlich-Morrow, Laura E., 42 Ridge rd., Rutherford
Ellmers, Basil J., 304 Milford av., New Milford
Essertier, Edward P., 275 State st., Hackensack
Essertier, Harland C., 263 Franklin av., Ridgewood
Evans, J. Lawrence, Jr., 254 Christie Hgts. st., Leonia
Fadden, Francis J., Jr., 275 Engle st., Englewood
Farmer, Vincent, 430 Union st., Hackensack
Farr, Walter J., 955 Queen Anne rd., Teaneck
Fermaglich, Harry B., 881 Garrison av., Teaneck
Ferrari, Andrew F., 196 Main st.. E. Rutherford
Fietti, Vincent G., 112 Ridge rd., Lyndhurst
Finke, George W., 237 State st., Hackensack
Finke, John H. D., 19 Hudson st., Hackensack
Fitzhugh, William F., 190 Euclid av., Ridgefield Park
Fitzpatrick, Leo J., 541 Churchill rd., West Englew'd
Fliegel, William M., 85 W. Passaic st., Maywood
Forte, F. Chester, 111 State st., Hackensack
Franklin, Sidney I., U.S.P.H.S.
Freeland, Frank, 281 State st., Hackensack
Friedman, Abraham I., 405 State st., Hackensack
Gatti, Joseph D., 92 E. Hunter av., Maywood
Gershman, Joseph G., 185 E. Madison av., Dumont
Gilady, Raphael, 205 Union st., Hackensack
Giordano, William C., 855 Broad av., Ridgefield
Gittelsohn, Isador, 700 Kinderkamack rd., River Ed.
Gitterman, David A., 519 Engle st., Englewood
Gladstone, Albert L., 886 Kinderkam'k rd.,River Ed.
Glick, Bernard, 307 Stuyvesant av., Lyndhurst
Goldberg, David, 336 Westwood av., Westwood
Goldfarb, Abraham, 52 Chestnut st., Rutherford
Gould, Werner, 219 Passaic st., Hackensack
Greenfield, Arthur W., 50 Anderson st., Hackensack
Greenfield, William J., 50 Anderson st., Hackensack
Grimes, Robert R., 815 Elm av., Teaneck
Groff, Parker A., 159 Washington av., Little Ferry
Gross, Robert J., 786 Palisade av., Teaneck
Grueninger, Edward F., Army
Guidice, Vincent W., Harrison av., Waldwick
Hagovsky, Albert J., 301 Hackensack st., Carlstadt
Halpern, Herman, 143 Engle st., Englewood
Halpern, Jesse O., Army
Hardy, Grace C., 60 Hillside av., Tenafly
Harryman, William K., 271 Union st., Hackensack
Hawes, Vernon L., 63 Church st., Ramsey
Helff, Joseph R., 1367 Teaneck rd., W. Englewood
Heller, George, 460 Engle st., Englewood
Hensle, Otto S., 210 Main st., Hackensack
Hillsman, R. Bryan, 268 Vandelinda av., Teaneck
Hirsch, John J., 191 Wallington av., Wallington
Hitzemann, Louis A., 35 Pangborn pl., Hackensack
Horowitz, Herman J., 872 Broad av., Morsemere
Hull, Donald B., 88 W. Ridgewood av., Ridgewood
Irwin, John H., 51 Tenafly rd., Englewood
Jacobitti, Edmund E., 491 Maywood av., Maywood
Jaslow, Seymour P., Godwin av., Wyckoff
Jenkins, Alvah R., 40 Armory st., Englewood
Johnson, G. Leonard, 390 Booth av., Englewood
Johnston, Sidney F., 365 Rochelle av., Rochelle Park
Jordan, Walter L., 145 Engle st., Englewood
Jukofsky, Isidore D., 335 Main st., Ridgefield Park
Kakascik, Emil J., 206 Palisade av., Garfield
Kastler, Franz, 54 Ames av., Rutherford
Keir, Floyd E., 308 Engle st., Englewood
Kelley, Charles B. P., 336 Engle st., Tenafly
Kennedy, Paul A., 147 Tenafly rd., Englewood
Kilts, Winfield S., 966 Garrison av., Teaneck
Kingma, John G., Goffle Hill rd., Midland Park
Kingslow, George L., 346 1st st., Hackensack
Knapp, Richard E., 25 Hudson st., Hackensack
Knight, William T., 515 Oradell av., Oradell
Knowles, George M., 403 Prospect av., Hackensack
Knox, Charles A., 138 Bergen av., Ridgefield Park
Knox, Harriet L., 390 Union st., Hackensack
Kraissl, Cornelius J., 230 Kinderkam'k rd., Hack'ns'k
Kristal, John, 292 Main st., Hackensack
LaBarba, Peter J., 163 Washington pl., Hasbr'k Hts.
Lamberto, Vito A., 422 Stuyvesant av., Lyndhurst
Lemmerz, Willard H., 184 Hackens'k st.,Wood-Ridge
Lesko, Stephen W., 234 Mt. Pleas't av.,E.Rutherford
Levitas, George M., 199 Fairview av., Westwood
Levitas, Irving M., Kinderkamack rd., Westwood
Levy, Jack D., 191 Union st., Hackensack
Lewis, Alice B., E. Saddle River rd., Saddle River
Little, Rufus R., Bergen Pines Hospital, Oradell
Littwin, Charles, 950 Queen Anne rd., Teaneck
Liva, Arcangelo, 100 Prospect av., Hackensack
Liva, G. Albin, Madison av., Wyckoff
Liva, Paul F., 280 Stuyvesant av., Lyndhurst
Loman, Samuel G., 139 Jefferson av., Cresskill
Lombardi, Frank L., 25 E. Clinton av., Bergenfield
Lord, C. Donald. 76 W. Ridgewood av., Ridgewood
Lowe, Louise, 210 Main st., Hackensack
Luria, Sanford A., 249 Queen Anne rd., Bogota
Lynch, Maurice M., 256 Summit av., Hackensack
Lyons, Romola L. K., 171 Meadowbr'k rd., Englewood
Macauley, Francis A., 819 Elm av., Teaneck
MacKellar, James M., 26 E. Clinton av., Tenafly
MacLaren, Philip J., 3 Tenafly Court, Tenafly
Maddren, Russell F., 372 Union st., Hackensack
Mader, A. Ivan, Jr., 430 Union st., Hackensack
Magee, William P., 1009 Abbott blvd., Palisade
Mancene, Edward M., 225 Main st., Little Ferry
Mark, Harold I., 1022 Garrison av., Teaneck
Markley, Luther A., Holy Name Hosp., Teaneck
Marx, Frederick J., 539 Kinderkam'k rd.,River Edge
McCormack, Frank C., 95 Tenafly rd., Englewood
McFeely, Percy R., 242 Palisade av., Bogota
McIlveen, Marion, 260 Godwin av., Ridgewood
McLane, A. Donald, 498 Engle st., Englewood
McLeod, Harry J., 71 Forest rd., Tenafly
Mears, William G., 216 Hillside av., Leonia
Megibow, Harold J., Main st., Ramsey
Meyer, Howard M., 400 Maple Hill dr., Hackensack
Miller, Herbert G., 38 Hawthorne st., Rutherford
Modrys, Walter F., 1400 Palisade plaza, Hudson Hts.
Mores, Herbert R., 321 Union st., Hackensack
Morrow, J. Lloyd, 42 Ridge rd., Rutherford
Morrow, Joseph R., 45 N. Broad st., Ridgewood
Moss, Jack W., Maple av., Wyckoff
Muller, Frederick L., 511 Broad st., Carlstadt
Mulligan, Luke A., 230 Central av., Leonia
Myers, Norman V., 41 Magnolia av., Tenafly
Neary, Edward R., Army
Nemiroff, Nathan, 348 Kinderkamack rd., Oradel
Netz, Lester W., 414 Main st., Hackensack
Nichols, Frank I., 52 Euclid av., Hackensack
Nicol, Lorenz C., 360 Larch av., Bogota
Olpp, John L., 100 E. Palisade av., Englewood
Olson, Vendela E., 100 Prospect av., Hackensack

Oren, Hyman, 74 Perry st., Park Ridge
Padden, Aloysius F., 15 Anderson st., Hackensack
Pagano, Peter, 324 Franklin av., Ridgewood
Pallen, Conde deS., 6 Passaic st., Rochelle Park
Patti, Frank A., 241 Broad av., Leonia
Pedevill, Joseph R., 232 Highland av., Palisades Park
Pellegrini, Vincent J., 315 Rochelle av.,Rochelle P'k
Perham, Roy G., 248 Boulevard, Hasbrouck Hts.
Pettit, Harry H., 138 Franklin av., Ridgewood
Phillips, Walter, 109 E. Palisade av., Englewood
Pindar, Irene D., 627 Queen Anne rd., Teaneck
Pingitore, Eufelia, 30 Martin ter., Hackensack
Pizzi, Peter J., Army
Placa, James A., 200 Oak st., Ridgewood
Policastro, Nelson C., 378 Union st., Hackensack
Prall, Henry E., 755 Anderson av., Cliffside Park
Prather, John W., 155 Washington av., Dumont
Protzman, Thomas B., 408 Conrad rd., Englewood
Prout, William B., 88 W. Forrest av., W.Englewood
Rader-Hoheb, Katherine, 5 Lincoln av., Rutherford
Rappaport, Doris I., 1363 Sussex rd., W. Englewood
Re, Natale M., 1003 Dearborn rd., Palisade
Reich, Samuel B., 286 Union st., Hackensack
Reinhold, H. E., 441 W. Englewood av., W.Englewood
Reitnauer, John S., 6 Standish ct., Tenafly
Richards, Ernest W., 374 DeWolf pl., Hackensack
Richardson, Charles A., Main st., Closter
Roberts, Charles D., 188 Sherwood pl., Englewood
Romano, Anthony M., 159 Westervelt av., Tenafly
Rooks, Wendell H., Wyckoff
Roth, Daniel B., 836 Garrison av., Teaneck
Rowe, Joseph A., 174 S. Maple av., Ridgewood
Rowohlt, George O., 150 E. Madison av., Dumont
Roylance, F. Dean, Jr., Closter Med. Group, Closter
Rube, Joseph, 145 Prospect st., Ridgewood
Rucker, William C., 408 Main st., Hackensack
Ruoff, Andrew C., III, 24 Cleveland av., Rivervale
Ryley, Harold W., 1 Lincoln pl., E. Rutherford
Salmeri, Edward J., Army
Sandler, Moses, 2013 Center av., Fort Lee
Sarajian, Aram M., 131 Ayres ct., W. Englewood
Sarla, Michael, 55 Hudson st., Hackensack
Scerbo, Ernest, 1-09 34th st., Warren Point
Schaberg, Frank J., 102 Pine st., Ridgewood
Scheer, Eli, 895 Queen Anne rd., Teaneck
Schiro, S. Robert, 73 Main st., Lodi
Schmidt, Walter W., 386 Palisade av., Cliffside Park
Schretzmann, Rudolph C., 60 D'nalds'n av., R'therf'd
Scullion, Arthur A., 460 Anderson av., Cliffside Park
Sealey, Henry J., 79 Washington av., Dumont
Segard, Christian P., 204 Glenwood av., Leonia
Seiler, Benjamin, 580 Palisade av., Cliffside Park
Sexton, Edward V., 936 Queen Anne rd., Teaneck
Seymour, Edward T., 55 Hillside av., Tenafly
Singer, Marie J., 139 E. Madison av., Dumont
Skvarla, John A., 17 Koster st., Wallington
Smaine, Enrique del C., 554 Hackensack st.,Carlstadt
Smith, Bryan A., 10 N. Monroe st., Ridgewood
Smith, Nehemiah E., 29 Bennett rd., Englewood
Snedecor, Spencer T., 210 Main st., Hackensack
Solworth, Lee, 308 Engle st., Englewood
Somers, Williard H., 157 Engle st., Englewood
Sosnow, Louis M., 51 Central av., Hillsdale
Spanz, William S., 546 Oradell av., Oradell
Spiegelglass, Abraham B., 417 Main st., Hackensack
Stassi, Anthony, 481 Passaic av., Lodi
Stein, Frederick, 620 Ridge rd., Lyndhurst
Taylor, Harold W., 247 Mountain rd., Englewood
Tennis, Edgar M., 375 Engle st., Englewood
terKuile, Reinold W., W. Ridgewood av., Ridgewood
Tether, Russell K., Main st., Closter
Toal, Joseph, 803 Prospect av., Ridgefield
Tomlins, Francis I., 97 Madison pl., Ridgewood
Toscano, George A., 305 Union st., Hackensack
Turner, Isabel B., 141 Sheffield av., Englewood
Tyson, Frances B., 101 Leonia av., Leonia
Utens, Max, Army
Vanderbeek, Stuart W., 143 Engle st., Englewood
Van Dyke, Joseph S., 42 Palisade blvd., Palisades Pk.
Vann, Dorothea D., 179 Hillside av., Englewood
Vann, Felix H., 179 Hillside av., Englewood
Van Winkle, Charles I., 79 Ridge rd., Rutherford
Verdon, Robert E., 682 Anderson av., Cliffside
Vita, Frank J., 695 Palisade av., Cliffside Park
Vroom, William L., 88 W. Ridgewood av., Ridgewood
Ward, Mary, 30 Engle st., Tenafly
Warren, Charles B., 181 Prospect av., Bergenfield
Webb, Wilson D., 210 Main st., Hackensack
Weiss, Abram, 314 DeMott av., Teaneck
Weiss, Samuel A., 786 Palisade av., Teaneck
White, Frank S., 916 Red rd., Teaneck
Whitman, Lloyd B., 7 W. Clinton av., Bergenfield
Whittaker, Neil M., 418 Main st., Hackensack
Widetsky, Alfred, 85 Broadway, East Paterson
Williams, Edith B., 70 Anderson st., Hackensack
Williams, William C., 9 Ridge rd., Rutherford
Wilson, Harrison B., 430 Union st., Hackensack
Winter, Gladys C., 805 Red rd., Teaneck
Witkoff, Ben.. 215 Terrace av., Hasbrouck Heights
Wolfe, Edward E., 895 Queen Anne rd., Teaneck
Wolowitz, Harry B., 20 Spring Valley av., Hack'ns'k
Worcester, George F., 220 Engle st., Englewood
Wry, Orlin V., 95 High st., E. Rutherford
York, James L., 331 River rd., New Milford

ASSOCIATE MEMBERS

Andrick, Eugene A., 99 Sheridan av., Hohokus
Audi, Eugene H., 46 Maple st., Glen Rock
Bassett, Samuel, 355 Washington av., Dumont
Bednarz, Stephen, 219 Maple av., Wallington
Brescia, James, 7 E. Franklin Turnpike, Waldwick
Campbell, Charles P., 397 Prospect av., Hackensack
Dallio, Salvatore V., 463 Passaic av., Lodi
Dana, Edward, 163 Prospect av., Hackensack
Delafrange, Kenneth M., 25 Westwood av., Westw'd
DeLuca, Louis, 323 E. Ridgewod av., Ridgewood
Dolan, Gerald J., 118 Broadway, Hillsdale
Drews, Francis F., Jr., 284 Broad av., Leonia
Duffy, Robert W., 314 Hamilton av., Hasbrouck Hts.
Dul, Emil J., 154 Plauderville av., Garfield
Friery, John F., 62 Broad st., Bergenfield
Garrett, Thomas A., 315 Park st., Hackensack
Goldstein, Daniel L., 210 Main st., Hackensack
Grant, Russell B., 210 Main st., Hackensack
Harwood, Harry L., 64 W. Central blvd.,Palisades Pk.
Hunziker, George P., 215 Clinton pl., West Englew'd
Johnson, Winton H., 210 Main st., Hackensack
Kassel, Mortimer H., 34 Elmwood ct., East Paterson
Kollar, Charles S., 268 Godwin av., Ridgewood
Liva, Vinicio G., 280 Stuyvesant av., Lyndhurst
Mason, Stuart A., 756 E. Ridgewood av., Ridgewood
McWhorter, John E., 115 Grand av., Englewood
Naclerio, Amedeo, 207 Hackensack st., Wood-Ridge
Newmann, Monroe E., 24 W. Salem st., Hackensack
Persico, Anthony, Col'b's and R'lr'd avs.,Harr'gt'n P.
Pindar, William A., Jr., 59 Bradley av., Bergenfield
Pollack, Roy, 715 Palisade av., Cliffside Park
Pramuk, Clarence, 764 Cedar lane, Teaneck
Rhodes, Harry, Jr., 171 Terrace av., Hasbrouck Hts.
Ross, Bernard, 30 E. Passaic st., Maywood
Rusin, Michael, 81 Monroe st., Garfield
Scialli, Vincent A., Bergen Pines Hospital, Oradel

Seidel, Reginald, 164 Maple st., Englewood
Silverman, Mendel, 84 Park av., Rutherford
Sklar, S. Harvey, 647 Anderson av., Cliffside Park
Sperber, Thomas J., 1367 Teaneck rd., W. Englewood
Susinno, Anthony M., 29 Roff av., Palisades Park
Vargish, Hildegard S., 268 Kinderkam'k rd., River E.
Vargish, Jacob, 268 Kinderkamack rd., River Edge
Vogel, Nathan F., 333 Main st., Ridgefield Park
Walker, Nelson C., 15 Anderson st., Hackensack
Wollack, Alfred, 74 Perry st., Park Ridge
Wren, James C., Main st., Closter

COURTESY MEMBERS

Carey, Benjamin, Westwood
Cocoa-Fernandez, Arthur F., Oradell
Denison, Ward C., Ridgewood
Hambright, Arthur M., Ramsey
Hardy, Stanton M., Montvale
Harreys, Charles W., Ridgewood
Opitz-Burton, Russell, Palisade
Pfeiffer, Alfred G., Paramus
Salter, Kent, Paterson
Twinem, Francis P., Hackensack

HONORARY MEMBERS

Burbank, Hugh E., Lyndhurst
Clock, Ralph O., Scarsdale, N. Y.
Hallett, Frederick S., Hackensack
Proctor, James W., Tenafly
Tidwell, George W., Rutherford

BURLINGTON COUNTY (3)

Society organized May 19, 1829. Regular meetings on second Thursday evening of each month except June, July and August, at Riverton Country Club, Riverton. Annual Meeting in May.

ACTIVE MEMBERS

Anderson, Richard D., 465 High st., Burlington
Atkinson, James Q., 63 Mill st., Vincentown
Barton, Amy S., 509 Chester av., Moorestown
Betts, R. Winfield, 22 N. Main st., Medford
Bray, William E., 41 Elizabeth st., Pemberton
Buckley, Richard T., Jr., 111 E. Main st.,Maple Shade
Busansky, Samuel T., Circle dr., Browns Mills
Cicione, Edward, 621 Highland av., Palmyra
Conroy, John S., 124 E. Broad st., Burlington
Curtis, Howard C., 224 E. Main st., Moorestown
Darlington, Emlen P., New Lisbon
Davis, E. Vernon, 306 E. Main st., Moorestown
Davis, Jacob M., 1400 High st., Burlington
Dickson, T. Bruce, 408 Main st., Riverton
Downs, Roscius I., 430 Cooper st., Woodbury
Elwell, Alfred M., Jr., 149 E. Main st., Moorestown
Fahrenbruch, Fred'k D., 101 Garden st., Mt. Holly
Fischbach, Adolph D., 108 Hanover st., Pemberton
Geary, Russell D., 337 Bridgeboro rd., Riverside
Gibson, Charles F., 131 E. Federal st., Burlington
Haldeman, Robert E., 34 Garden st., Mt. Holly
Hale, Matthew J., 467 High st., Burlington
Hartman, Luther M., 111 E. Main st., Maple Shade
Hebble, Howard M., 129 Chester av., Moorestown
Hornberger, J. Howard, 4th & Main sts., Roebling
Hunter, Edward R., 321 Union av., Delanco
Krasnitz, Alexander, Fairview Sana., New Lisbon
Kuder, Joseph M., 104 Garden st., Mt. Holly
Landis, Harry P., Jr., 901 Columbia av., Palmyra
LeFavor, Dean H., 619 Morgan av., Palmyra
Leonard, Bernard, 33 W. Union st., Burlington
Longsdorf, Harold E., 200 Garden st., Mt. Holly
Love, Elizabeth F., 142 E. Oak av., Moorestown
Lucas, W. Fred, 23 W. Broad st., Burlington
Manning, John W., III., 27 Elizabeth st., Pemberton
Mark, Harry B., 600 Elm ter., Riverton
Mazur, Edward F., 540 Bridgeboro rd., Riverside
McDonnel, Gerald E., 470 High st., Mt. Holly
Mendenhall, Clinton D., 412 F'rnsw'th av.,Bordent'n
Metzer, Emma P. W., 430 Fairview st., Riverside
Metzer, Freeman W., 428 Fairview st., Riverside
Mills, Charles S., 106 Lippincott av., Riverton
Muldoon, Edward J., 207 E. Union st., Burlington
Mulford, William P., 202 Warren st., Beverly
Munro, Charles A., Main st., Marlton
Newcomb, Marcus W., Browns Mills
Peacock, Arthur B., 201 E. Main st., Moorestown
Rachunis, Michael, 5th & Riverside avs., Roebling
Robbins, Morris A., 39 W. Main st., Columbus
Rodman, E. Warren, 612 Spruce st., Beverly
Sand, Abraham B., 207 E. Union st., Burlington
Schaeffer, Alan M., 229 Willow st., Delanco
Schisler, Milton M., 2nd & Church sts., Florence
Shapiro, Charles S., S. Forklanding rd., Maple Shade
Small, E. Lester, 30 Branch st., Medford
Sparks, Paul R., 102 W. Broad st., Burlington
Steitz, John A., 200 Garden st., Mt. Holly
Stokes, Joseph, 220 E. Main st., Moorestown
Stokes, S. Emlen, 129 Chester av., Moorestown
Strenski, John, 540 Bridgeboro st., Riverside
Summey, Thomas J., 800 Golf View rd., Moorestown
Thorne, Nathan, 119 Chester av., Moorestown
Tracy, George T., 222 Warren st., Beverly
Ulmer, D. H. B., 199 Chestnut st., Moorestown
Viteri, Luis E., 214 Main st., Mt. Holly
Voorhis, Charles F., 330 Morgan av., Palmyra
Voss, John C., 634 Thomas av., Riverton
Wagner, J. George, Riverbank, Delanco
Wells, William C. V., 220 Hazel av., Delanco
Wescoat, George N. A., 202 W. Main st., Moorestown
Whitaker, John C., 402 Lippincott av., Riverton
Wildman, Edward, 119 Chester av., Moorestown
Wyman, Edward H., 100 E. Broad st., Burlington
Ziccardi, Anthony V., 210 W. Main st., Maple Shade

HONORARY MEMBERS

Stokes, Joseph, Moorestown
Thorne, Nathan, Moorestown

CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets first Tuesday in each month, October to May, inclusive, with an outing in June. Annual Meeting in May.

ACTIVE MEMBERS

Amato, Charles P., 424 Broadway, Camden
Anderson, Wm. M., 20 Kings H'way, W., Hadd'nf'd
Andrus, David L., 805 Cooper st., Camden
Angus, Leslie R., 437 Kings H'way, E., Haddonfield
Asbell, Nathan, 326 Cooper st., Camden
Assante, M. Hugo, 120 White Horse pk., Clementon
Athey, Kenneth L., 3616 Westfield av., Camden
Baker, Banks S., 618 Benson st., Camden
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, Kirk B., 1303 Princess av., Camden
Barnshaw, Harold D., 406 Cooper st., Camden
Barroway, James N., 2714 Westfield av., Camden
Becker, C. Frederick, 620 Benson st., Camden
Beideman, Casper M., 5 W. Maple av., Merchantville
Bentley, David F., Jr., 406 Cooper st., Camden
Bernell, Stanley P., 1207 Haddon av., Camden
Betancourt, Raul R., 406 Cooper st., Camden
Bianco, John J., 523 Cooper st., Camden
Boudwin, Norman K., Laurel rd., Stratford
Bowen, Robert N., 419 Cooper st., Camden
Braun, William, 406 Cooper st., Camden
Brennan, Charles L. S., 14 S. Broadway, Gloucester
Brennan, John P., 14 Church rd., Merchantville
Brown, Stanley L., 517 Cooper st., Camden
Browning, Wm. J., 134 N. Centre st., Merchantville
Burns, Wilmer F., 267 White Horse Pike, Audubon
Bush, Ralph K., 23 E. Maple av., Merchantville
Butler, Samuel S., 1100 Kaighn av., Camden
Campbell, Dorothy C., 514 Cooper st., Camden
Carlander, Oswald R., 130 N. Broadway, Camden
Cavalli, Ralph D., N. Y. Shipbuilding Corp., Camden
Chesnick, Reuben B., 290 W. Clinton av., Oaklyn
Ciliberti, Frank J., Jr., Fifth and Pine sts., Camden
Clark, Ernest W., 407 Cooper st., Camden
Clark, Morris B., W. Pine and Atl. avs., Audubon
Cohen, Paul, 500 State st., Camden
Collier, Martin H., 406 Cooper st., Camden
Conlen, Richard, 523 Haddon av., Camden
Connell, James, 337 Monmouth st., Gloucester
Cooper, Robert A., 7137 E. Park av.,PennsaukenTwp.
Coxson, Harold P., Laurel rd., Stratford
Crist, Walter A., 432 Virginia av., West Collingsw'd
Crowley, Joseph W., 4005 Westfield av., Camden
Cunningham, Joel B., 801 Cooper st., Camden
Davis, Albert B., 511 Cooper st., Camden
Davis, J. Stannard, 55 Kings Highway, E.,Haddonf'd
Decker, Henry B., 527 Penn st., Camden
Deibert, Irvin E., 538 Cooper st., Camden
Deibert, Kirk R., Veterans Hosp., Nashville, Tenn.
Del Duca, Vincent P., 514 Cooper st., Camden
Dempsey, J. Harvey, Washington av., Berlin
Denbo, Elic A., 596 Benson st., Camden
Di Ielsi, Anthony J., 1013 S. 5th st., Camden
D'Imperio Francesco, 411 Cooper st., Camden
Donges, Clarence B., 442 Chambers av., Camden
Driscoll, C. D., 475 White Horse, Pike, W. Col'ngsw'd
Drossner, Jacob L., 1300 Park Blvd., Camden
Ebner, Paul G., 408 Overhill rd., Haddonfield
Ellis, Alexander, 519 Broadway, Camden
Ewing, Leslie H., 10 Broad st., Berlin
Eynon, Harold K., 563 Haddon av., Collingswood
Eynon, James R., 20 E. Knight av., Collingswood
Farrell, Edgar A. H., 26 Kings Highway, W. H'd'nf'ld
Fessman, John W., Clements Bridge rd., Runnemede
Filkins, Cedric E., 412 White Horse Pike, Audubon
Fisher, Stella C., 4401 Westfield av., Camden
Frantz, Max K., 624 S. 5th st., Camden
Fridrich, Harry E., 4172 Federal st., Camden
Friedenberg, Sidney, 2990 Alabama rd., Camden
Gamon, Robert S., 514 Cooper st., Camden
Geissler, Elmer E., 327 Monmouth st., Gloucester
German, George B., 15 W. Walnut av.,Merchantville
Gilbert, Philip D., 514 Cooper st., Camden
Girardo, Anthony J., 22 Taunton av., Berlin
Glover, L. L., 53 Kings Highw'y, W. Haddonf'ld
Goldman, Samuel, 527 Cooper st., Camden
Goldstein, Hyman I., 1325 Broadway, Camden
Gordon, Milton H., 12 N. 27th st., Camden
Gosper, Ralph W., 5719 W'stf'd av., Penns'kenTwp.
Grenhart, George W., 714 Market st., Camden
Griffey, William C., 1049 Haddon av., Collingswood
Griscom, Lee E., 604 Broadway, Camden
Hadley, C. Frazer, 210 W. Maple av., Merchantville
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont
Haines, Keith E., Broadway & Stevens st., Camden
Haines, Mabel C. S., 600 White Horse Pike, Audubon
Halbeisen, William A., 511 Cooper st., Camden
Hallinger, Earl S., 517 Cooper st., Camden
Hammett, Lee J., 760 N. 27th st., Camden
Hanson, Alfred S., 33 E. Cuthbert rd., Westmont
Harbeson, James P., III, 403 Cooper st., Camden
Haury, Victor J., Box 206, Wellsville, Kansas
Hays, Roy G., 527 Haddon av., Collingswood
Hemphill, Everett H., 274 Kings H'way, E., Had'nf'd
Hessert, Edmund C., 417 Cooper st., Camden
Hirshorn, Arthur, 539 Monmonth st., Gloucester
Hofer, William R., 125 Main st., Williamstown
Hollinshed, Beulah S., 600 Benson st., Camden
Horner, John I., 137 W. Kings Highway, Audubon
Howard, J. Edgar, 67 Kings H'way, W., Haddonf'd
Hughes, A. Joseph, 3rd & Cooper sts., Camden
Hughes, Frank J., 429 Cooper st., Camden
Hughes, Thomas E., 223 Cooper st., Camden
Hummel, Ernest G., 414 Cooper st., Camden
Hummel, Merwin L., 4715 Fulton st.,N.W.,Wash.,DC
Husted, Gerald W., 306 Eighth av., Haddon Heights
Imhoff, Robert E., 527 Penn st., Camden
Ironside, Paul A., 144 North dr., Haddonfield
Jablonski, John J., 1405 Kenwood av., Camden
Jack, H. Wesley, 538 Cooper st., Camden
Jackson, Chas. H., 1250 Park Blvd., Camden
Johnson, Herbert F., 429 Cooper st., Camden
Jones, John C., 805 Princeton av., Camden
Judson, G. Vernon, Jr., 722 Redan av., Haddonfield
Kain, Thomas M., 403 Cooper st., Camden
Kain, Thomas M., Jr., 403 Cooper st., Camden
Kay, Albert E., 5 W. Chestnut av., Merchantville
Keller, Earl B., Jr., 604 White Horse Pike, Oaklyn
Kerdasha, Richard F., 937 Monmouth st., Gloucester
Keyser, David, 1518 Baird av., Camden
Kimler, William D., 400 Collings av., Collingswood
Kinney, Albert G., 609 Clinton av., Haddonfield
Klarich, Philip, 512 Broadway, Camden
Kline, Oram R., 514 Cooper st., Camden
Klinger, John S., 1452 Mt. Ephraim av., Camden
Kutner, Charles, 211 N. Fifth st., Camden
Larossa, Ernest A., 561 Benson st., Camden
Lee, Benjamin F., 1416 Bradley av., Camden
Lee, Thomas B., 622 Cooper st., Camden
Lewis, Thomas K., 130 N. Broadway, Camden
Locke, Henrik W., N. Y. Shipbuilding Corp., Camden
Lovett, Joseph C., Municipal Hospital, Camden
MacAlpine, Kenneth B., 500 Chews Ldg. rd.,Had'nf'd
Magee, Edward S., 201 White Horse Pike, Audubon
Magee, Russell S., 201 White Horse Pike, Audubon
Mahaffey, J. Lynn, 406 Warwick rd., Haddonfield

Maldeis, Albertos M. K., 117 N. Sixth st., Camden
Manser, Ernest E., 321 Haddon av., Collingswood
Marcarian, Henry G., 917 Cooper st., Camden
McCallum, Arthur S.,213 Clements Bridge rd.,Bar'gt'n
McCarthy, Arthur M., 2772 Federal st., Camden
McConaghy, Thomas P., 10th & Cooper sts., Camden
McDermott, Vincent T., 511 State st., Camden
McGlade, Thomas H., 1225 Walnut ave., W.Col'gsw'd
McWilliams, Charles E., Church st., Blackwood
Mecray, Paul, Jr., 405 Cooper st., Camden
Mecray, Paul M., 405 Cooper st., Camden
Meyer, George P., 410 Haddon av., Camden
Murray, Edwin N., 400 Penn st., Camden
Musulin, Nicholas R., 514 Cooper st., Camden
Newmeyer, Joseph, 27th st. & Baird Blvd., Camden
Ondovchak, M. Frederic, Kings H'way, Mt. Ephraim
Ornaf, I. Edward, 1145 Thurman st., Camden
Osborn, Edward G., 3194 Alabama rd., Camden
Palmisano, Vincent S., 13 W. 6th av., Runnemede
Phillips, Claude B., 885 Haddon av., Collingswood
Pike, Charles E., 4 E. Haddon av., Oaklyn
Pinsky, Harry A., 209 S. 6th st., Camden
Pratt, Arthur G., 516 Cooper st., Camden
Price, Henry S., Jr., 150 Frazer av., Collingswood
Principato, Roberto, 402 Walnut st., Camden
Rapp, Robert F., 994 Haddon av., Collingswood
Read, William T., Jr., Cooper Hospital, Camden
Reilly, Joseph, 600 Newton av., Oaklyn
Rhone, David S., 1202 Haddon av., Camden
Riegert, Louis C., 808 Kings H'way, Haddon Hts.
Ristine, Edwin R., 123 Maple av., Westville
Roberts, Joseph E., Jr., 403 Cooper st., Camden
Rosner, Edwin, 788 Haddon av., Collingswood
Rudolph, John P., 108 W. Maple av., Merchantville
Russell, Karl S., 101 Dill av., Collingswood
Ruttenberg, Max, 303 Cooper st., Camden
Santor, Daniel, 15 W. Taunton av., Berlin
Santor, G. Frank, 3176 Westfield av., Camden
Schall, Reuben E., Seventh & Elm sts., Camden
Scheffler, Wilhelm A. H., 511 Cooper st., Camden
Schellenger, Edward A. Y., 429 Cooper st., Camden
Schrack, Helen F., 216 N. Fifth st., Camden
Schwartz, Henry C., Raritan av., Atco
Seiberling, Joseph D., 225 Redman av., Haddonfield
Seto, Stanford P. T., Box 138, Blackwood
Shaen, Edward, 701 N. 6th st., Camden
Shafer, Albert H., 405 Cooper st., Camden
Shafer, F. William, 634 Penn st., Camden
Sharp, Reuben L., 719 Cooper st., Camden
Shaw, Ernest B., 811 Collings av., W. Collingswood
Sheaffer, Clinton P., 241 Kings H'way, E., Had'nf'd
Shemeley, William G., Jr., 7 Haddon av., Camden
Sherk, A. Lincoln, 2647 Westfield av., Camden
Shipman, James S., 514 Cooper st., Camden
Shipps, Hammell P., 719 Coper st., Camden
Shope, Edward P., 807 Wilson Bldg., Camden
Shull, Elliott C., 517 Cooper st., Camden
Sieber, Isaac G., 204 Merchant st., Audubon
Skyer, Joseph, 3400 Federal st., Camden
Smith, Bertram H., 1000 Kings Highw'y,Hadd'nHts.
Smith, James D., 831 Stokes av., Collingswood
Snagg, William T., 719 Cooper st., Camden
Snape, William J., 573 Stevens st., Camden
Sochacki, Alexander, 1478 Mt. Ephraim av., Camden
Stein, Joseph M., 404A Boyd st., Camden
Stephenson, Daniel H., 2704 Westfield av., Camden
Stetser, Leland M., 920 Haddon av., Collingswood
Stone, Frank P., Laurel rd., Laurel Springs
Straus, Frederick W., 2708 Westfield av., Camden
Sufrin, Emanuel, 1529 Wildwood av., Camden
Summerill, Garnett, 330 Cooper st., Camden
Swiecicki, M. E., 317 Clements Bridge rd., Barr'ngton
Tatem, Henry R., Jr., Pine st.&Atlantic av.,Audubon
Thompson, P. H., 4612 W'stf'd av., Pennsauken Twp.
Traganza, Robert W., 428 Richey av., W.Collingsw'd
Warwick, Ralph A., 3300 Federal st., Camden
Waugh, Bascom S., 1882 S. 10th st., Camden
Weigert, Wolfgang U., 266 Marlton av., Camden
Weimann, Max L., 803 Station av., Haddon Heights
West, David H., Aspenwell Vet. Hosp.,Pittsburgh,Pa.
Whalen, Edward C., 942 Cooper st., Camden
Wheatland, Marcus F., Jr., 757 Kaighn av., Camden
Wiant, Herman E., 120 Windsor av., Haddonfield
Wiggins, Ulysses S., 1025 S. Fourth st., Camden
Williams, William C.,Blk.Horse pk.&Way.av.,Had.H.
Wilson, Isam E., 110 Chapel av., Merchantville
Wilson, Lester R., 3320 Federal st., Camden
Winter, Carl M., 1518 Collings rd., Camden
Witkowski, Joseph L., 1450 Mt. Ephraim av., Camd'n
Wright, Ralph S., 517 Cooper st., Camden
Wroblewski, Benj. M., 1166 Thurman st.. Camden
Yasskin, Hymen E., 575 Stevens av., Camden

HONORARY MEMBERS

Clements, Lavinia B., Haddonfield
Eaton, Arthur T., Haddon Heights
Lyon, Leslie C., Magnolia
Marcy, John W., Merchantville
Martin, William, Haddonfield
Pratt, William H., Camden
Rossell, Edward W., Colwick
Van Sciver, John E. L., Haddonfield

CAPE MAY COUNTY (5)

Society organized December 18, 1883. Eight regular meetings each year. Meets on fourth Tuesday, October to May inclusive. Semi-annual meeting in October. Annual Meeting in May.

ACTIVE MEMBERS

Bernheisel, Louis E., Tuckahoe
Brooks, George M., Cape May Court House
Cameron, C. Paul, Shore rd., Somers Point
Cohen, Maurice B., Pine & Pacific avs., Wildwood
Cooper, Jules, 723 Washington st., Woodbine
Cornwell, Robert A., 702 Sixth av., Ocean City
Crowe, Aldrich C., 735 Atlantic av., Ocean City
Cryder, Millard C., Cape May Court House
Dandois, George F., 220 E. Wildwood av., Wildwood
Eisenhower, J. S. D., 154 E. Spicer av., Wildwood
Fath, Marcus A., 108 E. Glenwood av., Wildwood
Haines, F. B. Lane, 503 Ninth st., Ocean City
Haines, Willits P., 503 Ninth st., Ocean City
Hirsch, Arthur, 811 DeHirsch av., Woodbine
Hornstine, Harry H., 4004 Pacific av., Wildwood
Hughes, Frank R., 910 Stockton av., Cape May
Hughes, Harold F., Ocean st. & Columbia av.,CapeM.
Hughes, Samuel B., 246 E. Pine av., Wildwood

Mace, Margaret, 2410 Atlantic av., N. Wildwood
Markowitz, Isidor, 115 Broadway, West Cape May
Mazzotta, Samuel, 5806 Pacific av., Wildwood
Moir, John A., 18 N. Main st., Cape May C'rt House
Monosson-Friedland, Ida, 200 N. East av., Vineland
Moon, Alexander C., 126 Decatur st., Cape May
Pettit, Herschel, 807 Wesley av., Ocean City
Schwarz, Leopold J., 237 E. Pine st., Wildwood
Smith, Marcia V., 821 Wesley av., Ocean City
Snyder, James A., Franklin st.& Sewell av.,CapeM.
Steel, William A., Beesleys Point
Townsend, John B., 824 Wesley av., Ocean City
Way, Clarence W., 4515 Landis av., Sea Isle City
Whiticar, John H., Box 235, Ocean City
Yingling, Paul L., 804 Wesley av., Ocean City

HONORARY MEMBERS

Diverty, Henry B., Woodbury
Quigley, Frederic J., Union City
Ulmer, Chester I., Gibbstown

CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets on the second Tuesday of October, December, February, April and June. Annual Meeting in April. Special scientific meetings are held in the evening in November, January, March and May.

ACTIVE MEMBERS

Aitken, Frank J., 62 N. Pearl st., Bridgeton
Anastor, Herbert C., 641 Wood st., Vineland
Bacon, Mary, 278 E. Commerce st., Bridgeton
Baker, Hugh W., 8th & Elmer sts., Vineland
Bellak, Ellis R., Leesburg
Berkowitz, Benjamin, 188 E. Commerce st.,Bridgeton
Bostwick, Delazon S., Cumberland Hotel, Bridgeton
Branin, Howard S., 200 W. Main st., Millville
Butcher, Charles, Heislerville
Corson, Kenneth E., 25 S. Myrtle st., Vineland
Cunningham, Charles, Jr., E. Landis av., Vineland
Davies, George A., 53 Front st., Elmer
Day, Samuel T., Main st., Port Norris
DeSantis, Orazio J., Tuckahoe
Friedland, Arnold J., 200 N. East av., Vineland
Fromkin, Charles, 20 Bank st., Bridgeton
Garrison, W. Sherman, Main st., Cedarville
Gray, Charles M., 6th & Grape sts., Vineland
Greene, Edwin C., 61 N. Pearl st., Bridgeton
Gricco, Anthony L., 830 Elmer st., Vineland
Harris, Maurice N., Irving av., Bridgeton
Henry, Norman, 739 Wood st., Vineland
Hirsch, Allen H., 10 N. 6th st., Vineland
Kauffmann, Louis J., 228 N. 2nd st., Millville
Knowles, James S., 318 N. Second st., Millville
Kolbe, Joseph T., 119 S. Second st., Millville
Kratka, William H., 188 N. Pearl st., Bridgeton
Kump, Albert B., 31 W. Commerce st., Bridgeton
Lang, Paul, 32 W. Commerce st., Bridgeton
Loder, Horace B., 225 E. Commerce st., Bridgeton
Loper, John C., 129 Atlantic st., Bridgeton
Lore, Harry E., Main st., Cedarville
Lyon, Earl C., 194 E. Commerce st., Bridgeton
Magolda, Anthony F., 727 Grape st., Vineland
Marchione, Nicholas E., 105 S. East av., Vineland
Mayhew, Charles H., 329 Pine st., Millville
Mezzetti, Alfred F., 220 S. 6th st., Vineland
Miller, H. Garrett, 203 E. Main st., Millville
Myatt, Leslie E., 98 N. Pearl st., Bridgeton
Neal, Charles B., Pine & 3rd sts., Millville
Palladino, Alessandro, 86 W. C'mm'rce st., Bridgeton
Pastore, Mario, East av. & Grape st., Vineland
Pino, Anthony, 196 Irving av., Bridgeton
Ramsey, F. Muriel, 310 E. Pine st., Millville
Rosen, Sol, 214 N. Second st., Millville
Scott, Leonard G., 496 E. Commerce st., Bridgeton
Sharp, Charles E., Main st., Port Norris
Sheppard, Alfred G., 309 Broad st., Elmer
Sheppard, Muse A., 102 Main st., Elmer
Sheppard, Thomas S., 21 E. Vine st., Millville
Siegel, Sidney L., 227 N. 2nd st., Millville
Thalheimer, Edward J., 7th & Plum sts., Vineland
Thomas, George N., 712 Wood st., Vineland
Walker, Ada H., 635 Landis av., Vineland
Walker, H. Burton, 635 Landis av., Vineland
Ware, Carl N., Bridgeton rd., Shiloh
Whaland, Berta, 117 Atlantic st., Bridgeton
Wilson, Charles W., 636 Wood st., Vineland
Wilson, Herbert H., 24 Bank st., Bridgeton
Winslow, John H., 27 S. Valley av., Vineland
Woodruff, Dare, 611 Elmer st., Vineland

HONORARY MEMBERS

Cornwell, Alfred, Bridgeton
Elmer, Matthew K., Bridgeton
Simkins, Raymond, Bridgeton

ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday of each month, October to May, inclusive. Annual Meeting is second Thursday in May.

ACTIVE MEMBERS

Abbamonte, Louis W., 226 N. Park st., East Orange
Abel, Arthur R., Orange Memorial Hosp., Orange
Abrams, Abram B., 299 Clinton av., Newark
Adelman, Benjamin B., 186 Clinton av., Newark
Adelson, Edward T., 201 Keer av., Newark
Agnew, Hobart M., 17 Plymouth st., Montclair
Albano, Edwin H., 144 Harrison st., East Orange
Albano, Frank J., 535 N. Seventh st., Newark
Albano, Joseph, 535 N. Seventh st., Newark
Alcamo, John H., 321 S. 9th st., Newark
Alexander, John W., 310 Main st., Orange
Alford, Ralph I., 83 Park st., Montclair
Allan, James S., 144 Harrison st., East Orange
Allen, Chester B., Jr., 42 Gordonhurst av., Montclair
Allen, Raymond N., 144 Harrison st., East Orange
Alling, Frederic A., 15 Washington st., Newark
Altman, Charles D., 63 Forest Hill rd., West Orange
Ambrose, Anthony, 31 Lincoln Park, Newark
Anderson, Robert C., 686 Mt. Prospect av., Newark
Anderson, William A., 1310 Broad st., Bloomfield
Annunziata, Augustine, 210 Central av., Orange
Antonius, Nicholas A., 27 W. Market st., Newark
Antopol, William A., 24 Stengle av., Newark
Anuario, Charles B., 365 S. Center st., Orange
Applebaum, Irving L., 31 Lincoln Park, Newark
Areson, Wm. H., 153 Bellevue av., Upper Montclair
Arons, Harry, 31 Lincoln Park, Newark
Ash, Samuel, 866 So. 13th st., Newark
Aszody, Paul, 340 Waverly av., Newark
Auerbach, Friedrich, 490 Stuyvesant av., Irvington
Autorino, Ralph R., 10 Harrison av., Montclair
Bachmann, William, 87 Hillcrest ter., East Orange
Bacote, Ernest F., 78 Barclay st., Newark
Bagg, Linus W., 31 Lincoln Park, Newark
Baime, Jules E., 72 Prospect st., East Orange
Baiocchi, Pascal J., 203 Hunterdon st., Newark
Baker, Maclyn F., 987 Sanford av., Irvington
Balis, Samuel B., 192 Roseville av., Newark
Balsamo, Joseph J., 224 So. Eighth st., Newark
Balson, Zachary D. B., 49 Osborne ter., Newark
Barbella, Joseph D., 498 N. 13th st., Newark
Barkhorn, Charles W., 223 Roseville av., Newark
Barkhorn, Henry C., 45 Johnson av., Newark
Barnard, Frank G., 79 Hawthorne pl., Montclair
Barrett, John E., 25 Elwood pl., Newark
Barrett, Joseph F., 230 Parker av., Maplewood
Bauch, Solomon, 564 Hawthorne av., Newark
Baum, Felix, 10 Elm court, South Orange
Baum, Lewis F., 46 Chancellor av., Newark
Baum, Samuel, 10 Osborne ter., Newark
Bauman, Everett O., 862 S. 13th st., Newark
Bauman, Rush C., 92 High st., Nutley
Becker, Martin, 66 Hawthorne av., East Orange
Beer, Sanel, 48 Wilson av., Newark
Beling, C. Abbott, 15 Washington st., Newark
Bell, Horace O., Essex Co. Isolation Hosp., Belleville
Belott, Louis V., 529 Park av., Orange
Bender, Louis, 285 Ridgewood av., Newark
Bengelsdorf, Aron, 29 Clinton pl., Newark
Benz, George L., 32 W. Market st., Newark
Berardinelli, Carmine G., 92 Eighth av., Newark
Berg, Samuel, Army
Berger, William A., 346 Roseville av., Newark
Bergman, Meyer W., 31 Lincoln Park, Newark
Berlin, Morris R., 84 Girard pl., Newark
Berney, Irving, 31 Lincoln Park, Newark
Berney, Ruth V., 16 Lyons av., Newark
Bernhard, William G., 174 Summit av., Summit
Bernstein, Arthur, 668 Clinton av., Newark
Bernstein, Julius, 584 S. Tenth st., Newark
Besson, Franklin J., 999 Clinton av., Irvington
Beyer, Othmar J., 42 Laurel av., Irvington
Bianchi, Angelo R., 184 Hunterdon st., Newark
Binder, Charles I., 188 Oakland rd., Maplewood
Birdsall, Clarence A., 9 Smull av., Caldwell
Bissett, John V., 29 Hawthorne av., East Orange
Biunno, Anthony J., 53 Finlay pl., Newark
Blackburne, George, 490 Central av., Newark
Blanchard, Kenneth, 144 Harrison st., East Orange
Blaustein, Maurice L., 859 S. 13th st., Newark
Bleiberg, Jacob, 31 Lincoln Park, Newark
Block, Marcus T., 177 Bloomfield av., Newark
Block, Max, 48 N. Fullerton av., Montclair
Block, Milton, 342 Union av., Irvington
Bocchini, Joseph A., 366 S. 12th st., Newark
Bokor, Emery, 819 S. 12th st., Newark
Bolten, Bernard, 377 Osborne ter., Newark
Bonomo, Michael J., 587 S. 10th st., Newark
Booken, Gerald J., 1 Johnson av., Newark
Borrus, Joseph C., 333 Keer av., Newark
Borsher, Irving P., Army
Bove, Joseph, 306 Lincoln av., Orange
Bozzi, Robert, 406 Roseville av., Newark
Brackett, Elizabeth R., 371 Franklin av., Nutley
Bradford, Stella S., 26 N. Mountain av., Montclair
Bradley, Muriel, 284 Highland av., Upper Montclair
Brady, Frank J., 1038 S. Orange av., Newark
Brady, Raymond J., 777 Clinton av., Newark
Brams, William M., 7 Madison av., Newark
Brandman, Otto, 39 S. Munn av., East Orange
Braun, Gustav A., 24 Centre st., South Orange
Breitstadt, Charles A., 157 Elwood av., Newark
Brien, William M., 449 Main st., Orange
Briggs, Henry, 144 Harrison st., East Orange
Brim, Anne J. S., Edgemere Hotel, East Orange
Broadnax, Mary E., 176 Eagle Rockway, Montclair
Brodkin, Eva T., 365 Osborne ter., Newark
Brodkin, Henry A., 365 Osborne ter., Newark
Brodkin, Louis A., 365 Osborne ter., Newark
Brotman, Harry, 808 S. 11th st., Newark
Brotman, Morton M., 90 Avon av., Newark
Brown, Chester R., 22 Midland av., Arlington
Brown, Chester T., Prudential Ins. Co., Newark
Brown, Edward V., 9 Park av., Caldwell
Brown, Harold W., 27 S. Fullerton av., Montclair
Brown, Lewis W., 160 Roseville av., Newark
Browne, George F., 284 Highland av., UpperMontcl'r
Brunkow, Charles D., 31 Lincoln Park, Newark
Buckley, Jermiah L., 666 Franklin av., Nutley
Buckner, Roscoe W. H., 20 Rose st., Newark
Buermann, August, III, Navy
Bull, Louis M., 92 Heller Parkway, Newark
Bull, William J., 98 Park st., Montclair
Burke, Leonard P., 30 Lakeside av., Verona
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
Burnett, Hayes J., 1 Hawthorne pl., Montclair
Burnett, Lawrence F., 386 Roseville av., Newark
Burpeau, William P., 80 Woodland av., East Orange
Burrill, Benjamin B., Jr., 85 Maolls av., Bloomfield
Burstein, Frank, 1115 S. Broad st., Newark
Burstein, Leo Q., 702 S. 15th st., Newark
Burstein, Rachel, 31 Lincoln Park, Newark
Busch, Herman, 38 Johnson av., Newark
Bush, Archer C., 40 Union st., Montclair
Butan, Louis, 479 Highland av., Orange

Buvinger, Charles W., 50 Washington st., E. Orange
Byck, Louis, 794 S. 11th st., Newark
Byrnes, Elizabeth W., 160 Central av., Orange
Bythewood, Alton E., Jr., 145 W. Market st.,Newark
Cacciarelli, Robert A., 517 Roseville av., Newark
Caggiano, Anthony P., Navy
Cahill, Laurence A., 361 Lafayette st., Newark
Calasibetta, Charles J., 37 Longfellow av., Newark
Caldwell, Donald M., Prudential Ins. Co., Newark
Calvert, William C., 225 Gregory av., West Orange
Camche, Leo J., 250 Renner av., Newark
Cameron, Arthur E., 59 Somerset st., Newark
Cameron, Edwin A., 186 S. Burnett st., East Orange
Campbell, Everette L., 144 Harrison st., East Orange
Campbell, William, 144 Harrison st., East Orange
Cantalupo, Emidio, 95 Nichols st., Newark
Cantelmo, Alphonse L., 144 Harrison st.,EastOrange
Cappiello, William, 352 Seventh av., Newark
Caputo, Anthony R., 301 Washington av., Belleville
Carbone, Francesco N., 440 Central av., Orange
Cardwell, Edgar P., 965 Broad st., Newark
Carlisle, Paul E., 763 Broad st., Newark
Carpenter, Charles A., 30 Francis pl., Caldwell
Carr, Josephus C., 75 13th av., Newark
Carrigan, Francis P., 305 Roseville av., Newark
Carrol, Wilfred, 51 Ingraham pl., Newark
Casale, John B., 359 Bloomfield av., Newark
Castellano, Martin G., 330 Roseville av., Newark
Cerone, Daniel M., 138 N Arlington av., E. Orange
Cestone, Canio, 1425 Pompton av., Little Falls
Cetrulo, Gerald I., 234 Mt. Prospect av., Newark
Chamberlain, Richard R., 30 Lenox pl., Maplewood
Chattin, J. Franklin, 195 Boyden av., Maplewood
Cherashore, Harry N., 363 Centre st., Nutley
Chernus, Jack, 860 S. 12th st., Newark
Cheskin, Louis J., 31 Lincoln Park, Newark
Chiaramida, Joseph, Essex Mt. Sana., Verona
Chimacoff, Hyman, 159 Elizabeth av., Newark
Chmelnik, Abraham G., City Hospital, Newark
Christoph, Francis T., 483 Prospect st., Maplewood
Ciccone, Edwin L., 261 Roseville av., Newark
Citrino, Robert J., 345 Centre st., Nutley
Clarken, Joseph A., 27 Ingraham pl., Newark
Clement, Baxter L., 15 Washington st., Newark
Coburn, J. Wesley, 144 Harrison st., East Orange
Coffin, Henry F., 116 N. Ninth st., Newark
Cohen, I. Elvin, 561 Elizabeth av., Newark
Cohen, Maurice, 106 Valley rd., Montclair
Cohen, Max, 60 Ridge rd., North Arlington
Cohen, Sidney L., 29 Girard pl., Newark
Cohen, Sidney P., 509 Franklin av., Nutley
Cohn, George M., 867 S. 11th st., Newark
Cohn, Hermann, 393 Clinton av., Newark
Cohn, Royal M., 740 Clinton av., Newark
Coleman, Russell M., 76 N. Clinton st., East Orange
Colmer, M. Jonas, 31 Lincoln Park, Newark
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood
Colton, Ethan T., Jr., 38 Park st., Montclair
Comando, Harry N., 695 Clinton av., Newark
Conlon, Philip J., 25 James st., Newark
Connamacher, Harold S., 671 Springfield av.,Newark
Connolly, John J., 180 Ballantine Pkwy., Newark
Connolly, Richard N., 117 Fifth st., Newark
Conti, Horace, U.S.P.H.S.
Cook, Hugh F., 21 Roseville av., Newark
Cooper, David P., 62 S. 10th st., Newark
Cooperman, William, 647 Market st., Newark
Cornish, Charles H., 673 Prospect st., Maplewood
Cott, A. Alan, 47 Lincoln Park, Newark
Coughlan, Ella A., 10 Oakwood av., Orange
Coughlin, Frank J., 100 Magnolia av., Arlington
Covino, Louis L., 44 Oakland ter., Newark
Cox, John C., 55 Woodland rd., Maplewood
Cox, William W., 79 S. Fullerton av., Montclair
Crane, Charles G., 78 Farley av., Newark
Crapanzano, Domenico, Essex Co. Hosp.,CedarGrove
Craster, Charles V., Plane and William st., Newark
Crawford, Georgina U., 65 Prospect st., E. Orange
Crecca, Anthony D., 376 Roseville av., Newark
Crecca, William D., 111 Park av., Newark
Cregar, John S., 440 Harrison st., East Orange
Crossfield, Henry C., 144 Harrison st., East Orange
Crystell, Edward H., 4 Hawthorne av., Nutley
Cucinella, Anthony B., 361 Lafayette st., Newark
Cupaiuoli, Richard A., 30 Lenox pl., Maplewood
Curtis, Elbert A., 65 Central av., Newark
D'Addario, Anthony R., 132 Broadway, Newark
D'Agostini, Alfred J., 41 Columbia av., Newark
D'Agostini, Robert J., 41 Columbia av., Newark
Dailey, Edward S., 141 Connett pl., South Orange
D'Alessandro, Arthur J., 15 Salem st., Newark
D'Ambola, Philip R., 21 S. Sixth st., Harrison
D'Amico, Thomas V., 70 Fairview av., Verona
Dane, Charles, 163 Kilburn pl., South Orange
Dane, John, 61 Scotland rd., South Orange
D'Angelo, Joseph C., 330 Washington av., Belleville
Dann, Frederick J., 65 Girard pl., Newark
Dante, Pasquale, 393 Millburn av., Millburn
Danzis, Louis, 31 Lincoln Park, Newark
Danzis, Maximillian, 31 Lincoln Park, Newark
Darby, I. Kermit, 1 Convent av., N. Y. C.
Darden, Walter T., 149 W. Kinney st., Newark
Daron, Simeon, 31 Lincoln Park, Newark
Davidson, Eric W., 295 Montgomery st., Bloomfield
Davidson, Henry A., R. D. 2, Flemington
Davidson, Maurice M., 128 Grant av., E., Roselle Pk.
Davies, George W., 35 Fairview av., Verona
Davis, Louis, 825 S. 10th st., Newark
Davis, Thomas C., 30 Old Short Hills rd., Millburn
Dear, Abraham L., 23 Synott pl., Newark
DeFilippis, Ralph L., 228 Tremont av., Orange
DeFronzo, Morando, 180 Fairmount av., Newark
DeGerome, James H., 10 Ridgewood av., Glen Ridge
DeHart, George K., 132 Sunset av., Verona
Deignan, William L., 257 Dodd st., East Orange
Delaney, Oscar M., 59 Seeley av., Arlington
Del Deo, Nicholas V., 49 State st., Newark
DeLeonardis, James V., 94 Jefferson st., Newark
Del Guercio, Olindo, 342 Clifton av., Newark
DeLia, Emilio, 25 Crane st., Newark
Della Fera, Lucien F., 206 First av., Newark
Della Ragione, Mario, 120 Second av., Newark
Del Negro, Albert E., 402 Roseville av., Newark
DeMichele, Roland V., 436 Ridge st., Newark
Denes, Oscar, 402 Centre st., Nutley
Denholtz, Emanuel, 16 Harrison pl., Irvington
Dennison, Alfred D., Jr., 601 Ridgew'd rd., Maplew'd
DePalma, Anthony F., 533 Mt. Prospect av., Newark
DePhillips, Benedict R., 228 Clifton av., Newark
DeTroia, Frederick C., 40 12th av., Newark
Deutel, Oscar R., 265 Newark av., Bloomfield
DeVincentis, Henry, 285 Henry st., Orange
Devlin, Arthur D., 138 Isabella av., Newark
Devlin, Hugh J., 72 Thomas st., Newark
Dias, Joseph L., 17 Lombardy st., Newark
Dieffenbach, Richard H., 570 Mt.Prosp't av.,Newark
Diener, Samuel, Army
DiFino, Felix J., 172 Edison pl., Newark
DiGiacomo, Harry E., 195 Hunterdon st., Newark
DiGiacomo, William H., 223 Fairmount av., Newark
Dinge, Ferdinand C., 67 S. Munn av., East Orange
DiNorcia, Joseph, 498 W. Market st., Newark
Donahue, William J., 71 S. Ninth st., Newark
Donchi, Sol M., 9 Madison av., Newark
Donnelly, John H., 634 S. 20th st., Newark
Dorris, Earl D., Essex Co. Hosp., Cedar Grove
Dowds, Samuel C., 218 Walnut st., Montclair
Dranow, Paul, 233 Franklin av., Nutley

Drapkin, Berta, 31 Lincoln Park, Newark
Dreskin, Jacob L., 34 Lyons av., Newark
Drewniany, Bernardine, 548 Page av., Lyndhurst
DuBois, Morris G., 769 High st., Newark
Duffy, Edward P., Jr., 52 Edgewood av., Nutley
Dulany, Theodore L., 170 W. Market st., Newark
Dulin, Everett V., 144 Harrison st., East Orange
Dunn, Theodore B., 35 Park pl., Bloomfield
Durchlag, E. Nelson, 12 Myrtle av., Irvington
Dwork, Harold K., 1 Hansbury av., Newark
Ebenfeld, Samuel W., 344 High st., Newark
Echikson, Joseph I., 31 Lincoln Park, Newark
Eck, Daniel B., 144 Harrison st., East Orange
Edelen, James J., 100 S. Munn av., East Orange
Edelson, Edmond, 127 Lehigh av., Newark
Ehrlich, Edward, 838 S. 13th st., Newark
Ehrlich, William E., 31 Lincoln Park, Newark
Eichler, Bernard B., 221 Midland av., Montclair
Ein, William B., 31 Lincoln Park, Newark
Einhorn, Samuel E., 241 16th av., Newark
Eisenberg, David S., 31 Lincoln Park, Newark
Eisenstodt, Lester W., 31 Lincoln Park, Newark
Ellis, Arthur J., 282 Broad st., Newark
Emerson, Linn, 303 Park av., Orange
Enimer, S. Wolfe, 31 Lincoln Park, Newark
Englander, Charles, 41 Hillside av., Newark
English, John T., 110 Yale av., Irvington
Epstein, Harry B., 31 Lincoln Park, Newark
Epstein, William M., 322 E. Westfield av., Roselle P.
Erdman, George L., 15 Washington st., Newark
Erler, Robert E., 360 Prospect st., South Orange
Ervin, Millard B., 36 Canterbury lane, Westfield
Etheridge, Charles H., 433 Prospect st., East Orange
Evans, Charles H., 144 Harrison st., East Orange
Evans, David P., 144 Harrison st., East Orange
Ewing, Harvey M., 31 Trinity pl., Montclair
Fader, Ferdinand, 350 Springdale av., East Orange
Fager, Rudolph O., 53 Park pl., Bloomfield
Failing, Brayton E., 31 Lincoln Park, Newark
Fanburg, Sol J., 31 Lincoln Park, Newark
Farb, Harry H., 21 Clinton pl., Newark
Farkas, Morris, 163 High st., West Orange
Fasano, Giovanni, 194 S. Seventh st., Newark
Faughnan, Rose C., 97 High st., Passaic
Fava, Philip V., 355 Sanford av., Newark
Fechner, Julius, 362 Clinton av., Newark
Fein, Bernard, 585 Elizabeth av., Newark
Feinsod, Samuel N., 1305 Clinton av., Irvington
Feldman, Frank H., 115 Lyons av., Newark
Fendrick, Edward, 17 Watson av., East Orange
Ferguson, William E., City Hospital, Newark
Fern, Samuel S., 122 Elizabeth av., Newark
Feuer, Joseph A., 653 Elm st., Arlington
Fink, A. Elston, 489 High st., Newark
Fink, Irving E., 71 Lincoln Park, Newark
Finkel, Joshua, 853 S. 11th st., Newark
Finkelstein, Abe S., 670 Clinton av., Newark
Finkler, Rita S., 35 Leslie st., Newark
Finnerty, Urban R., 71 Park st., Montclair
Fischbein, Martin M., 976 Sanford av., Irvington
Fischer, David D., 35 Randolph pl., Newark
Fischer, Edward J., 29 Ashwood ter., West Orange
Fischer, Louise, 31 Lincoln Park, Newark
Fischman, Harold H., 326 Avon av., Newark
Flanagan, James F., 569 Mt. Prospect av., Newark
Flanagan, John J., 173 Roseville av., Newark
Flax, Charles H., 71 Baldwin av., Newark
Flax, Ira I., 890 S. 16th st., Newark
Flax, Jacob L., 31 Lincoln Park, Newark
Fleischmann, Viola G., 103 Scotland rd., S. Orange
Fleming, Joseph A., 247 Claremont av., Montclair
Flicker, David J., 82 Clinton av., Newark
Floody, Robert J., 324 Kingsland st., Nutley
Flower, Morrie A., 39 Lincoln Park, Newark
Flynn, Edward A., 176 Washington av., Belleville
Foley, James F., 344 N. Grove st., East Orange
Ford, Theodore R., 144 Harrison st., East Orange
Fort, J. Irving, 306 Roseville av., Newark
Forte, Daniel L., 36 Nevins st., Rutherford
Forte, Frank S., 318 Roseville av., Newark
Fortunato, Samuel J., 90 Kenwood pl., E. Orange
Fost, William H., 107 Franklin st., Belleville
Foster, Herbert W., 2 Erwin Park, Montclair
Fowler, Royale H., 744 Broad st., Newark
Frame, Dorothy L., 15 Highland av., Glen Ridge
Francy, Donald G., 314 Stuyvesant av., Lyndhurst
Frank, Geza M., 491 Springfield av., Newark
Frank, Simon C., 62 Ridge rd., North Arlington
Franklin, Frank A., 256 S. Centre st., Orange
Fratantuno, Michael J., 14 Vermont av., Newark
Freeman, George C., Prudential Ins. Co., Newark
Freeman, Richard D., 317 Carteret pl., Orange
Freinkel, Jacob, 2 Hillside av., Newark
Friedlander, Kurt F., 25 S. Munn av., East Orange
Friedman, Harry, 721 S. 16th st., Newark
Friedman, Hyman, 1096 Sanford av., Irvington
Fritsch, Alfred, 82 Lyons av., Newark
Froelich, Joseph C., 74 Ingraham pl., Newark
Fruchtbaum, Robert P., 431 Franklin av., Nutley
Furman, Benj. A., 31 Roseville av., Newark
Furst, Nathan J., 299 Clinton av., Newark
Furst, William, 188 Clinton av., Newark
Galioto, Frank M., 188 Ampere Parkway, Bloomfield
Gamba, Joseph, 388 Fairmount av., Newark
Gambacorta, Leopoldo, 397 N. 13th st., Newark
Gamsu, George, Army
Ganley, Arthur J., 390 Park av., East Orange
Ganot, Frank I., 392 Ridge st., Newark
Gardam, Joseph W., 16 Longfellow av., Newark
Gardner, Kenneth E., 45 Fremont st., Bloomfield
Gaylor, Earl L., Jr., 144 Harrison st., East Orange
Geannette, Ernest D., 14 Harrison av., Montclair
Gehl, Raymond H., 114 Lyons av., Newark
Gehl, Sidney H., 65 Wolcott ter., Newark
Gelb, Jerome, 84 W. Alpine st., Newark
Gennell, Ernest, 298 Parker st., Newark
George, Melbourne E. W., 744 Broad st., Newark
Gerard, Patrick D., 364 Roseville av., Newark
Gerhardt, Paul E., 718 S. 17th st., Newark
Gershenfeld, David B., 20 Hillside av., Newark
Glardina, John S., 341 Walnut st., Newark
Giardina, Vincent J., 102 Jefferson st., Newark
Gibbins, A. Leslie, 60 Roseville av., Newark
Gibson, Augustus, Mendham
Giffoniello, Arthur A., 334 Roseville av., Newark
Gifford, William R., 247 Park av., East Orange
Gilbert, Samuel M., 353 Washington av., Belleville
Gilman, Chas. M. B., R.F.D., Box 327 B, Red Bank
Gilmour, John R., Navy
Ginsberg, Leon, Essex County Hosp., Cedar Grove
Giuffra, Frank, 161 Park st., Montclair
Giuliana, Robert A., 31 Central av., Newark
Glass, Oscar, 838 S. 12th st., Newark
Glass, Willlam H., 144 Harrison st., East Orange
Glazier, Jesse T., 670 Sanford av., Newark
Gluckman, I. Edward, 78 Johnson av., Newark
Gluckman, Saul K., 78 Johnson av., Newark
Glynn, S. Robert, 54 Girard pl., Newark
Godfrey, Alan O., 231 Roseville av., Newark
Goehring, Harrison D., Mountainside Hosp., Montcl'r
Goeller, Jacob D., 1165 W. Clinton av., Irvington
Goffman, Emanuel, 316 Claremont av., Montclair
Goldberg, Bernard R., 31 Lincoln Park, Newark
Goldberg, Harold H., 814 S. 10th st., Newark
Goldberg, Louis E., 31 Lincoln Park, Newark
Goldberg, Samuel A., 169 Gregory av., W. Orange
Golden, Clement H., 109 Weequahic av., Newark
Goldman, Jerome, 1 Johnson av., Newark

Goldman, Lester M., 53 Leslie st., Newark
Goldmann, Joseph, 103 N. Walnut st., East Orange
Goldstein, Henry Z., 31 Lincoln Park, Newark
Goldstein, Samuel M., 40 Johnson av., Newark
Goodman, Kenneth, 141 Park av., East Orange
Gordon, A. Julius, 351 Roseville av., Newark
Gorten, Manfred L., 669 Elizabeth av., Newark
Grant, Francis, Army
Grant, William F., 309 Roseville av., Newark
Grasso, Anthony P., Army
Gray, John W., 142 Clinton av., Newark
Greenberg, Jacob L., 189 16th av., Newark
Greenberg, Samuel, 46 Johnson av., Newark
Greenfield, Bernard H., 691 Clinton av., Newark
Greenfield, Herbert, 31 Lincoln Park, Newark
Greenfield, Leonard S., 691 Clinton av., Newark
Greenwald, Eugene, 100 Hollywood av., Hillside
Greenwald, Theo. L., 44 Maple av., Morristown
Greenwood, Samuel B., 190 Clinton av., Newark
Greer, Melvin A., 190 Washington st., Bloomfield
Gregory, Mildred G., 64 N. Ninth st., Newark
Greifinger, Marcus H., 31 Lincoln Park, Newark
Greifinger, William, 22 Vassar av., Newark
Griffin, Guy B., 197 S. Centre st., Orange
Griffith, Roy, 909 Broad st., Newark
Gross, Irving, 16 Grove av., Verona
Grossblatt, Philip, 31 Lincoln Park, Newark
Gruber, William L., 680 Clinton av., Newark
Grubin, Harold, 690 Clinton av., Newark
Grundorfer, Joseph, 201 Lyons av., Newark
Grunt, Louis, 80 Millington av., Newark
Gulick, James B., 363 Carteret pl., Orange
Gullord, Edward G., 284 Bellevue av., UpperMontcl'r
Gutowski, Walter T., 104 Grove ter., Irvington
Hahn, Katherine B., 372 Thornden st., South Orange
Hahn, William H., 198 Clinton av., Newark
Haley, Paul W., 719 Sanford av., Newark
Haller, Olga, 182 Roseville av., Newark
Halpern, Melvin M., 493 Central av., Newark
Halprin, Harry, 8 Washburn pl., Caldwell
Halsey, Levi W., 61 Church st., Montclair
Hamilton, Robert G., 92 Main st., Orange
Hanan, James T., 11 The Crescent, Montclair
Hand, Frederick G., 119 Irvington av., South Orange
Hansen, Harold T., 153 Irvington av., South Orange
Hantman, Harold, 196 Roseville av., Newark
Harden, Albert S., 510 W. Market st., Newark
Harden, Albert S., Jr., 551 Ridgewood rd., Maplew'd
Harris, Morris, 102 Broad st., Bloomfield
Hartman, Winfield L., Jr., 7 Fielding court, S. Orange
Harvey, Robert K., 711 Kearny av., Arlington
Harvey, Thomas W., 59 Main st., Orange
Hauck, Lydia R. B., 644 Stuyvesant av., Irvington
Hauck, William H., 644 Stuyvesant av., Irvington
Hawkes, E. Zeh, 84 Washington st., Newark
Hawkes, Stuart Z., 84 Washington st., Newark
Hayes, Gerald W., 86 Hawthorne av., East Orange
Heineken, Theodore S., 17 Park pl., Bloomfield
Heller, Abraham R., 494 Belgrove dr., Arlington
Heller, Nathan B., 31 Lincoln Park, Newark
Hendlich, Milton G., 24 Johnson av., Newark
Henle, Carye-Belle, 31 Lincoln Park, Newark
Hennig, Paul F., 688 Stuyvesant av., Irvington
Hermann, John H., 197 S. Centre st., Orange
Herndon, Lewis S., 144 Harrison st., East Orange
Herold, Harvey T., 850 S. 13th st., Newark
Hersh, David H., 163 Huntington ter., Newark
Hertzberg, Irving, 586 Kearny av., Kearny
Hewson, George F., 21 Roseville av., Newark
Heyman, Arthur, 89 Lincoln Park, Newark
Hicks, Alfred M., Essex Mountain Sana., Verona
Higi, Joseph E., 61 Hawthorne av., East Orange
Hill, Robert H., 227 Roseville av., Newark
Hillman, Ernest C., Jr., 15 Washinton st., Newark
Hilton, Clarence O., 556 N. Seventh st., Newark
Hinckley, Livingston S., 182 Clinton av., Newark
Hirsch, Theodore, 842 S. 13th st., Newark
Hobart, Richard T., 454 Park st., Upper Montclair
Holderith, Albert E., 15 Virginia av., Livingston
Holler, Henry G., 234 Montclair av., Newark
Holmes, George J., 17 Elizabeth av., Newark
Holtz, Harry M., 299 Clinton av., Newark
Hooton, Thomas C., 31 Trinity pl., Montclair
Hopping, Richard A., 15 Washington st., Newark
Horland, Aaron H., 37 Chancellor av., Newark
Horland, Ephraim, 99 Lincoln Park, Newark
Horn, Harry, 622 Stuyvesant av., Irvington
Horn, Max, 850 S. 11th st., Newark
Hosp, Paul H., 842 S. 12th st., Newark
Howard, James W., 199 Lorraine av., Up. Montclair
Howell, Thomas W., 219 N. Maple av., East Orange
Hubach, Maximilian F., Jr., 307 M'tg'mry st., Blmfd.
Hubbard, Robert Y., Hewitt
Huber, William H., 587 Prospect st., Maplewood
Huberman, John, 853 S. 12th st., Newark
Hughes, Lee W., 965 Broad st., Newark
Hulett, Albert G., 20 Hawthorne av., East Orange
Humphries, Robert E., 637 Central av., East Orange
Hurff, J. Wallace, 671 Broad st., Newark
Hymowitz, Ben, 66 Baldwin av., Newark
Iatesta, Matthew, 9 Wheeler st., West Orange
Ill, Edmund W., 477 Mt. Prospect av., Newark
Ill, Herbert M., 42 Woodland av., Glen Ridge
Inge, Hutchins F., 205 So. Orange av., Newark
Irwin, Francis T., 51 Forest av., Caldwell
Irwin, James R., 330 Washington av., Belleville
Isaac, Benoit C., 83 Central av., Orange
Israeloff, Howard H., 1038 Clinton av., Irvington
Jackson, George H., 2092 Morris av., Union
Jacobs, Benjamin, 1612 Clinton pl., Hillside
Jacobs, William, 1030 Stuyvesant av., Irvington
Jaeckle, Charles E., 136 Evergreen pl., East Orange
James, Bart M., 15 Washington st., Newark
Janifer, Clarence S., 208 Parker st., Newark
Jarvis, Daniel G., 31 Lincoln Park, Newark
Jaso, James V., 710 Varsity rd., South Orange
Jedel, Meyer, 125 4th st., Newark
Jenkins, R. Jewett, 683 High st., Newark
Jennings, Robert E., 117 Washington st., E. Orange
Jessurun, Samuel H., 613 High st., Newark
Johnson, Robert A., 393 Roseville av., Newark
Jonitz, Robert, 153 S. Grove st., East Orange
Judge, John F., 33 Hazelwood av., Newark
Just, Francis, 564 High st., Newark
Kaderabek, Erwin J., 144 Harrison st., East Orange
Kahrs, Grace M., 375 Mt. Prospect av., Newark
Kalb, S. William, 416 Clinton pl., Newark
Kallen, Arnold M., 21 Leslie st., Newark
Kalter, George E., 640 Prospect st., Maplewood
Kaney, Emil M., 167 Centre av., New Rochelle, N. Y.
Kaplan, Henry L., 17 Weequahic av., Newark
Kaplan, S. Bernard, 31 Lincoln Park, Newark
Katzin, Eugene M., 50 Baldwin av., Newark
Kauder, Warren G., 299 Clinton av., Newark
Kaufman, Jerome G., 299 Clinton av., Newark
Kavanaugh, Daniel E., 566 Mt. Prospect av.,Newark
Kearney, Edward P. J., Army
Kearney, John F., 238 Hilton av., Maplewood
Kearney, Paul A., Army
Keats, Sidney, 31 Lincoln Park, Newark
Keim, William F., Jr., 15 Washington st., Newark
Keith, Theodore R., 656 Bloomfield av., Nutley
Kelemen, Nicholas M., 315 Central av., East Newark
Kempe, George, 963 Caldwell av., Union
Kennedy, William M., Essex MountainSana.,Verona
Kenney, John A., 39 Madison av., Montclair
Kern, E. Clarence, 45 Park st., Montclair

Kern, Meyer J., 118 Johnson av., Newark
Kerns, Francis J., 526 W. Market st., Newark
Kessell, John S., Army
Kessler, Henry B., 666 Clinton av., Newark
Kessler, Henry H., 53 Lincoln Park, Newark
Kiessling, Charles E., 763 Broad st., Newark
Kiley, John E., 94 Park st., Montclair
Kimmel, Charles, 488 Broad st., Bloomfield
King, Louis I., 33 N. Oraton Pkwy., East Orange
Kinley, John W., 111 Clinton av., Newark
Kirkby, Cyril S., 45 Woodland av., Glen Ridge
Kirkman, Leroy G., 176 Roseville av., Newark
Kirkwood, Allan S., 53 Union st., Montclair
Klein, Andrew J. V., 73 Lincoln Park, Newark
Klein, Edward C., Jr., 73 Lincoln Park, Newark
Kleinberger, Harry H., 274 Millburn av., Millburn
Kleinman, Maurice, 101 Clinton av., Newark
Klenk, Joseph P., 328 Belleville av., Bloomfield
Kline, George L., 423 Essex av., Bloomfield
Klosk, Emanuel, 808 S. 12th st., Newark
Kobes, John J., 138 Kearny av., Kearny
Koch, James, 776 S. 19th st., Newark
Koeck, George P., 29 White ter., Nutley
Kohn, Leo, 86 Park pl., South Orange
Kolodin, Abraham, 98 Broad st., Bloomfield
Kornfeld, Werner, 645 Central av., East Orange
Kosterlitz, Henry H., 640 Stuyvesant av., Irvington
Kraemer, Manfred, 234 Roseville av., Newark
Kraker, David A., 31 Lincoln Park, Newark
Krichbaum, Carroll E., Army
Krone, William F., 31 Lincoln Park, Newark
Krug, Alfred J., 1460 W. Clinton av., Irvington
Kruger, William, 31 Lincoln Park, Newark
Kummel, Max, 31 Lincoln Park, Newark
Kunz, Harold G., 15 Highland av., Glen Ridge
Kuperman, Henry L., 237 16th av., Newark
Lafferty, Elton B., 69 Orange av., Irvington
Landesman, William, 187 Kearny av., Kearny
Lane, Austin W., 98 Prospect st., East Orange
Larkey, Irving G., 95 Shanley av., Newark
Leaman, Granville M., 182 N. Grove st., E. Orange
Le Bel, Louis J. B., 165 Grant av., Nutley
Leber, Otto H., 56 Church st., Montclair
Lee, John J., 309 Park av., Orange
Lee, Robert E., 24 Great Oak drive, Short Hills
Leeds, Leonard W., 701 Stuyvesant av., Irvington
Leff, Abraham, 37 Fulton st., Newark
Leff, Charles O., 5 Elm Court, South Orange
Leff, William A., 321 Wyoming av., South Orange
Lefkovics, Sidney C., 41 Clinton pl., Newark
Lehman, David J., Jr., 140 Roseville av., Newark
Lehman, Irving J., 31 Lincoln Park, Newark
Lemkin, Samuel, 71 Pomona av., Newark
Levin, Joseph, 831 S. 13th st., Newark
Levin, Murray, 20 Callamore dr., West Orange
Levine, Edward P., Army
Levine, Philip, 20 Hillside av., Newark
Levinson, David M., 850 S. 11th st., Newark
Levinson, Louis J., 43 S. Pierson rd., Maplewood
Levinson, Robert M., 824 S. 12th st., Newark
Levison, William, 75 Lincoln Park, Newark
Levitt, Jesse N., 26 Clinton pl., Newark
Levy, Anna L., 32 S. Munn av., East Orange
Levy, Julius, 357 Irving av., South Orange
Lewandowski, Edmund E., 2 Smalley ter., Irvington
Lewis, G. Rae, 458 Washington av., Belleville
Liccese, Emanuel, 84 Jefferson st., Newark
Licks, Frederick C., 64 Scotland rd., So. Orange
Lieb, Robert L., 61 Lincoln Park, Newark
Lieb, Saul, 90 Treacy av., Newark
Liegner, Ben, 858 S. 12th st., Newark
Lilien, Bernard B., 1191 Clinton av., Irvington
Lilien, Milton, 1191 Clinton av., Irvington
Lincoln, Jennings S., 140 Watchung av.,Up.Montcl'r
Linz, Curt, 561 Franklin av., Nutley
Lippman, Harold, 68 Livingston av., Newark
Lipstein, William, 707 Prospect st., Maplewood
Livingston, Bernard, 30 Park av., Caldwell
Livingston, Paul, 299 Main st., East Orange
Loder, Joseph S., 924 S. 17th st., Newark
Loeser, Lewis H., 188 Clinton av., Newark
Lohman, Herman, 91 Spruce st., Newark
Lomhoff, Irving I., Army
Long, John F., 82 Grand pl., Arlington
Longo, James J., 74 Ridge rd., N. Arlington
Longshore, Walter E., Jr., 216 Oakwood av., Orange
Lovell, John F., 1013 Clinton av., Irvington
Lowenstein, Aaron, 860 S. 11th st., Newark
Lowenstein, Harry A., 96 Milford av., Newark
Lowits, Otto, 78 Clinton av., Newark
Lowrey, James H., 79 Congress st., Newark
Luban, Benjamin, 730 High st., Newark
Luce, Henry A., 12 Mt. Vernon av., W. Orange
Lundblad, Walter E., 75 Prospect st., East Orange
Luongo, Federico, 212 S. Centre st., Orange
Lupo, Domenico, 763 Broadway, Newark
Lurie, Solomon I., 21 Hillside av., Newark
Lurie, Wolf, 223 E. Fifth st., Plainfield
Lutz, William M., 3 Southern Slope dr., Millburn
Lynch, Albert E. O., 257 Orange road, Montclair
Lynn, Hugh B., Pompton Turnpike, Pompton Plains
Lyon, Archibald, 115 Ridge rd., North Arlington
Lyons, James V., 333 Park av., Orange
Maas, Max A., 329 Clinton av., Newark
Mabey, J. Corwin, 242 Claremont av., Montclair
Macaluso, Dominic C., 475 Washington av.,Belleville
MacArt, J. Harold, 14 Overhill rd., South Orange
MacArthur, Clymont, 219 Roseville av., Newark
MacMillan, C. Wright, 4 Duryea rd., Up. Montclair
Macpherson, Elwood H., 34 Rawley pl., Millburn
Maffeo, Carl E., 149 Van Buren st., Newark
Maggio, George A., 419 Roseville av., Newark
Maggio, Nicholas A., 130 Fleming av., Newark
Magovern, Thomas F., 228 S. Orange av., S. Orange
Mahood, Herbert L., 86 Durand rd., Maplewood
Malsel, Irving, 327 Renner av., Newark
Makarchek, Sigmund J., 249 Broad st., Bloomfield
Mamlet, Alfred M., 33 Johnson av., Newark
Mancusi-Ungaro, Elviro, 268 Mt. Prospect av.,New'k
Mancusi-Ungaro, Lodovico, 156 Mt. Pr'sp't av.,Nwk.
Manfro, Gerard J., 35 Newark st., Newark
Marcus, Donald, 987 Sanford av., Irvington
Margolis, Alfred, 736 Sanford av., Newark
Margulies, Charles, 188 High st., Nutley
Marin, Robert B., 85 Park st., Montclair
Marks, Zelda I., 200 Clinton av., Newark
Marquis, Dean W., 144 Harrison st., East Orange
Marquis, W. James, 12 Hawthorne av., E. Orange
Marra, Rocco S., 221 Park av., Orange
Martin, William P., 25 Holland rd., South Orange
Martland, Harrison S., City Hospital, Newark
Masciocchi, Thomas A., 316 Park av., Orange
Mason, Virgil A., 144 Harrison st., East Orange
Massengill, Fulton, 233 Heywood av., Orange
Massey, J. Bruce, 68 W. Market st., Newark
Masterson, John F., 98 Myrtle av., Irvington
Matheke, George A., 555 William st., East Orange
Matheke, Otto G., 328 Sussex av., Newark
Matheke, Otto G., Jr., 328 Sussex av., Newark
Matheson, Gilchrist E., 144 Harrison st., E. Orange
Matthews, Clifford B., 1180 Raymond Blvd., Newark
Matthews, William F., 180 Walnut st., Montclair
Mauer, Richard E., 109 S. Midland av., Arlington
Maurer, K. Virginia, 16 Prospect rd., Livingston
May, Ernst A., 157 Harrison st., East Orange
McAveney, Thos. F. G., 32 S. Munn av., East Orange
McCarroll, E. Mae, 59 Hillside pl., Newark
McCauley, Francis J., 140 Roseville av., Newark

McCormick, James E., 775 Elizabeth av., Newark
McCroskery, James H., 396 N. Arl'gt'n av.,E.Orange
McGuinn, William B., 617A Central av., East Orange
McGuire, John J., 2 Gould av., Newark
McKeown, George H. C., 350 Fifth av., N. Y. C.
McKim, William F., 317 Roseville av., Newark
McLaughlin, William B., Army
McLellan, George A., 19 Hawthorne av.,East Orange
McVay, Edward A., 234 Lafayette st., Newark
Medd, John C., 25 Curtis pl., Maplewood
Meehan, Martin M., 339 Washington av., Belleville
Meeker, Irving A., 581 Valley rd., Upper Montclair
Meinhard, Fred, 154 Van Buren st., Newark
Meisel, David B., 818 S. 12th st., Newark
Mele, Vincent, 851 S. Orange av., East Orange
Mellen, Stanley H., 1 Park pl., Bloomfield
Menk, Paul E., 31 Lincoln Park, Newark
Merkelbach, Walter P., 288 Broad st., Bloomfield
Merliss, Eugene, 386 Clinton av., Newark
Mermod, Camille, 15 Washington st., Newark
Merrick, Evelina, 142 Clinton av., Newark
Merselis, John G., 110 Irvington av., South Orange
Messina, Thomas, 128 Park av., East Orange
Metsky, Joseph, 777 High st., Newark
Meurlin, Alfred, 144 Harrison st., East Orange
Mierau, Ernest W., 1096 Sanford av., Irvington
Miller, Eugene L., 63 Baldwin av., Newark
Miller, Herman P., 815 S. 12th st., Newark
Miller, I. Irwin, 675 Sanford av., Newark
Miller, Joseph A., 364 Prospect st., South Orange
Miller, Lucille F., 31 Webster pl., Orange
Miller, Nathan, 835 S. 12th st., Newark
Miller, Ralph, 43 Girard pl., Newark
Minard, Edwy L., 140 Fourth av., East Orange
Minier, Carl L., 153 Mt. Pleasant av., W. Orange
Miningham, William D., 18 Hedden ter., Newark
Minnefor, Charles A., 1164 S. Orange av., S. Orange
Mitchell, Augustus J., 59 South st., Newark
Mitchell, Walter L., Jr., 160 Roseville av., Newark
Modeski, Chester J., 73 N. 10th st., Newark
Modny, Michael T., 262 Ridgewood av., Glen Ridge
Moeckel, Clarence W., 63 S. Fullerton av., Montclair
Monaco, Saverio A., 293 Camden st., Newark
Moncada, Salvatore, 99 Franklin st., Belleville
Moore, Dean C., 391 Highland av., Orange
Moore, John P., 16 Richmond st., Newark
Moress, Edward J., 1524 Maple av., Hillside
Moretti, John J., 534 S. Clinton st., East Orange
Morgan, Browne, 32 Benson st., Bloomfield
Morton, Thomas V., Jr., 48 Willard av., Bloomfield
Motzenbecker, Peter F., 680 High st., Newark
Mount, Walter B., 21 Plymouth st., Montclair
Mullin, Eugene F., 500 Sanford av., Newark
Mullin, Raymond J., 76 Shanley av., Newark
Murphy, Thomas W., Jr., Navy
Murray, Harrold A., 624 Mt. Prospect av., Newark
Nacca, Carl A., 46 Cleveland st., Orange
Nadel, Charles I., 1013 Clinton av., Irvington
Nappi, Pasquale E., 433 Mt. Prospect av., Newark
Nash, Alexander E., 30 Forrest av., Verona
Nash, Herman S., 865 S. 11th st., Newark
Nataro, Joseph, 192 Littleton av., Newark
Nataro, Maurice, Nichols Gen. Hosp., Louisville,Ky.
Nemzek, William P. B., 8 Hedden ter., Arlington
Nevius, William B., 75 Prospect st., East Orange
Newman, Grace T., 339 Grove st., Montclair
Newman, Julius, 318 Highland rd., South Orange
Ney, J. Marshall, 443 Baldwin rd., Maplewood
Nicola, Toufick, 96 Gates av., Montclair
Nimaroff, Meyer, 203 E. Wash'gt'n blvd.,Grove C.,Pa.
Noll, Louis, 1383 Clinton av., Irvington
Novich, Max, 262 Schley st., Newark
Nussbaum, Harvey E., 31 Lincoln Park, Newark
Nyiri, William A., 863 S. 12th st., Newark
Oberlander, Gertrude, 866 S. 13th st., Newark
O'Connor, Bernard A., 47 Central av., Newark
O'Connor, Dennis F., 27 S. Kingman rd., S. Orange
O'Connor, Michael J., 98 Shanley av., Newark
O'Connor, Paul A., 342 Roseville av., Newark
O'Crowley, Clarence R., 31 Lincoln Park, Newark
Offenkrantz, Frederick M., 72 Hansbury av.,Newark
O'Grady, Michael J., 228 Franklin av., Nutley
Olini, Joseph J., 30 W. Market st., Newark
O'Lini, Louis J., 30 W. Market st., Newark
O'Neill, Charles L., 671 Broad st., Newark
O'Neill, Charles L., Jr., 671 Broad st., Newark
Onorato, Vincenzo R., 66 Christopher st., Montclair
Opdyke, Gordon M., 52 Claremont av., Verona
Openchowski, Mieczyslaw, 399 Mt. Pr'sp't av.,New'k
Oransky, Marvin, 534 S. 11th st., Newark
Orloff, Samuel, 59 Girard pl., Newark
Ormsby, Thomas J., 1180 Raymond Blvd., Newark
Orris, Harold J., 172 Lyons av., Newark
Orton, Henry B., 224 Delavan av., Newark
Ostrowski, Sigismund J., 265 Broad st., Bloomfield
Outwin, Richard N., Army
Paddock, Royce, 965 Broad st., Newark
Palmer, Gideon H., 81 Evergreen pl., East Orange
Palmer, Henry S., 128 Court st., Newark
Panitch, William, 90 Baldwin av., Newark
Pannullo, John N. P., 266 Van Buren st., Newark
Papera, John J., 8 Washington pl., Caldwell
Parent, Sol, 51 Baldwin av., Newark
Parker, John E., 385 Park av., Orange
Parkes, Morey, 33 Park av., Caldwell
Parsonnet, Aaron E., 3 Madison av., Newark
Parsonnet, Eugene V., 89 Lincoln Park, Newark
Pascall, Thomas M., 197 Lincoln av., Newark
Pattyson, Ralph A., 144 Harrison st., East Orange
Paul, George A., 788 Lyons av., Irvington
Paul H. Carl, 30 Westville av., Caldwell
Pavia, John R., 48 Mountainview av., East Orange
Payne, Guy, Essex Co. Hosp., Cedar Grove
Payne, Guy, Jr., 56 Prospect st., Verona
Pecora, Samuel, 599 Mt. Prospect av., Newark
Peer, Lyndon A., 15 Washington st., Newark
Pellecchia, Leonard J., 109 Parker st., Newark
Pelliciari, Donald, 577 Hamilton rd., South Orange
Pendexter, Sidney E., 11 S. Arlington av., E. Orange
Pennington, Alfred W., 398 N. Maple av., E. Orange
Pentecost, Salvador D., 14 Clarem't av., Maplewood
Perham, Bertram S., 199 Lorraine av., Up. Montclair
Perlmutter, Irving K., 20 Hillside av., Newark
Permison, Michael, 15 Fabyan pl., Newark
Perrone, Anthony J., 456 Roseville av., Newark
Petrone, Peter A., 81 Roseville av., Newark
Petry, William, 109 Treacy av., Newark
Phillips, Algernon A., 212 W. Market st., Newark
Picardi, Armand A., 256 Littleton av., Newark
Pilch, Arthur G., 1 Willard av., Bloomfield
Pilloni, Louis, 91 Beach st., Bloomfield
Pincus, Isidore, 138 Clinton av., Newark
Pinto, Joseph A., 50 N. 11th st., Newark
Pizzi, Francis W., 15 S. Cedar Parkway, Livingston
Pizzi, Mario V., 205 Park av., Orange
Plant, James S., 51 13th av., Newark
Pois, John, 67 Scotland rd., South Orange
Poller, Frederick K., 681 Stuyvesant av., Irvington
Pollis, Nicholas L., 642 High st., Newark
Pollock, Samuel L., 730 Prospect st., Maplewood
Polow, Benjamin, 190 Clinton av., Newark
Pomeranz, Raphael, 31 Lincoln Park, Newark
Potter, Raymond T., 144 Harrison st., East Orange
Prestifilippo, Silvestro, 105 Glenridge av., Montclair
Preston, Perry B., 12 Palm st., Newark
Price, Charles W., Essex County Hosp., Cedar Grove
Probst, Everett W., 276 Willow av., Lyndhurst
Proctor, Jesse E., 15 N. 13th st., Newark

Provenzano, Samuel, 317 S. 10th st., Newark
Quad, Clifford W., 52 Northfield av., West Orange
Quinn, Edward D., 323 Belleville av., Bloomfield
Rachlin, Harry T., 396 Union av., Irvington
Rados, Andrew, 31 Lincoln Park, Newark
Ram, Nathan H., Army
Rampond, James R., 579 Springdale av., E. Orange
Ranson, Briscoe B., Jr., 144 Harrison st., E. Orange
Rapalski, Adam J., Army
Rathgeber, Charles F., 18 William st., East Orange
Rattenne, Edward, 540 Mt. Prospect av., Newark
Ravitz, Samuel F., Army
Rawitz, Sidney B., 42 Chancellor av., Newark
Reeve-Allen, Jane, 42 Gordonhurst av., UpperM'tcl'r
Reich, Abraham L., 177 Grove rd., South Orange
Reich, Emma, Essex Mountain Sana., Verona
Reich, Henry, 31 Lincoln Park, Newark
Reich, Mortimer, 705 Elizabeth av., Newark
Reilly, Christopher J., 331 13th av., Newark
Reilly, John V., 520 Sanford av., Newark
Reinartz, Paul V., 763 Broad st., Newark
Reinfeld, Abraham G., 354 Clinton av., Newark
Reinhardt, Warren I., 276 Springdale av., E. Orange
Reissman, Erwin, 31 Lincoln Park, Newark
Remondelli, Raphael E., 216 Littleton av., Newark
Renzulli, Francesco, 228 S. Seventh st.. Newark
Resch, Henry U.. 185 Liberty st., Bloomfield
Restaino, Charles F., 465 Parker st., Newark
Rettig, Isidor L., 36 Milford av., Newark
Revere, Seth D., 303 Colorado av., Chickasha, Okla.
Ribbans, Robert C., 63 Central av.. Newark
Rich, Charles, 191 Littleton av., Newark
Rich, Harry H., 29 Broad st., Newark
Rich, Wallace E., Essex County Hosp., Cedar Grove
Richardson, Marvin T., Army
Richlan, Alfred, 173 Third st., Newark
Ricketts, Henry E., 25 Shephard av., Newark
Riffin, Irving M., 419 Park st., Upper Montclair
Riggs, Vincent J., 334 Springdale av., East Orange
Rinzler, Elliot, 211 Roseville av., Newark
Ripley, E. Warren, 56 Church st., Montclair
Rizzolo, Edward M., 523 Union av., Belleville
Robbin, Lewis, 18 Clinton pl., Newark
Robbins, Charles M., 31 Lincoln Park, Newark
Robbins, Eugene, 909 Broad st., Newark
Roberts, Allison H., 26 S. 9th st., Newark
Roberts, David C., 3 Glen Oaks av., Summit
Roberts, William A., 11 Park av., Caldwell
Robertson, Euston S., 500 Belgrove dr., Arlington
Robie, Theodore R., 144 Harrison st., East Orange
Robinson, Louis H., 31 Lincoln Park, Newark
Rocco, Frank, 729 Summer av., Newark
Rogers, Robert H., 49 Ninth av., Newark
Roh, Robert F., 198 Clinton av., Newark
Romano, Patrick J., 310 Central av., Orange
Rommer, J. Jay, 25 Ingraham pl., Newark
Rosamilia, Ralph E., 480 N. Seventh st., Newark
Rose, Salvatore J., 242 Ivy court, Orange
Roseman, Herman I., 41 Clark st., Bloomfield
Rosen, Charles D., 115 S. Munn av., East Orange
Rosen, Emanuel, 692 High st., Newark
Rosen, Frank L., 33 Johnson av., Newark
Rosenbaum, Samuel X., 261 Main st., West Orange
Rosenberg, L. Charles, 11 Murray st., Newark
Rosenberg, Lillian M., 334 Bloomfield av., Montclair
Rosenberg, Max, 1585 Wyndmoor av., Hillside
Rosenthal, Arnold J., 41 Renner av., Newark
Rosenthal, Oscar J., 54 Van Ness pl., Newark
Rosenthal, Sydney, 200 Clinton av., Newark
Ross, Ira S., 188 Clinton av., Newark
Rost, Adolf S., 461 Mountainview av., Orange
Roston, Mark A., 63 Hansbury av., Newark
Roth, Ferdinand L., 98 S. Munn av., East Orange
Roth, Oswald H., 210 Littleton av., Newark
Rothgesser, Jerome C., 783 Bergen st. ,Newark
Rothhouse, Burnet, 142 Hunterdon st., Newark
Rothschild, Daniel L., 31 Lincoln Park, Newark
Rothseid, Abraham, 29 Scheerer av., Newark
Rozsa, Stephen, 837 S. 11th st., Newark
Rubin, Abraham A., 240 Holmes st., Belleville
Rubino, Nicholas M., 67 N. Fourth st., Newark
Ruccia, Arthur, 464 Clifton av., Newark
Rumage, William T., 513 Sanford av., Newark
Runyan, William J., 106 Broad st., Bloomfield
Russomanno, Raymond L., 227 Clifton av., Newark
Salmon, George G., Jr., 243 Harrison st., E. Orange
Salsberg, Ralph H., 23 Johnson av., Newark
Samson, Norman D., 281 Kearny av., Kearny
Samuel, Jerome H., Army
Santora, Philip J., 361 Roseville av., Newark
Saporito, Archibald R., 119 Ridge rd., N. Arlington
Saracino, Frank J., 107 Grand pl., Arlington
Saslow, Benjamin I., 102 Shanley av., Newark
Saslow, Stella K., 102 Shanley av., Newark
Savel, Lewis E., 73 Shanley av., Newark
Sax, Max T., Army
Sbarra, Francesco C. N., 189 Roseville av., Newark
Schaaf, Royal A., 413 Mt. Prospect av., Newark
Schaefer, Eugene P., 12 Harrison pl., Irvington
Schaffer, Barney, 431 Washington av., Belleville
Schaffer, Nathan, 172 S. Arlington av., East Orange
Schectman, Vera, 385 Osborne ter., Newark
Scheiber, Geza, 769 Kearny av., Arlington
Scheller, George A., 65 Old Short Hills rd., Millburn
Scher, Maurice A., 137 Lyons av., Newark
Schiffmann, Samuel, 107 Spruce st., Newark
Schmukler, Jacob, 16 Johnson av., Newark
Schneider, Charles A., 694 Clinton av., Newark
Schneider, Louis, 874 S. 13th st., Newark
Schoenau, Carl W., Bellevue Hosp., New York City
Schotland, Clement E., 31 Lincoln Park, Newark
Schram, William S., 325 Belmont av., Newark
Schramm, Joseph A., 572 High st., Newark
Schreck, Harry, 192 Roseville av., Newark
Schulsinger, Samuel, 80 Clinton av., Newark
Schulte, Herbert A., 701 Clinton av., Newark
Schults, Anna R., 25 Abington av., Newark
Schurman, Francis H. C., 35 Smull av., Caldwell
Schwartz, Harold, 50 Baldwin av., Newark
Schwartz, Mortimer L., 636 Stuvesant av., Irvingtton
Scott, Harold R., 68 Central av., Orange
Scott, Norman M., 31 Clinton st., Newark
Scranton, Charles W., 59 Washington st., E. Orange
Seidler, Victor B., 16 Plymouth st., Montclair
Seidman, Edwin A., 580 High st., Newark
Seidman, Joshua I., Army
Seifert, Edwin A., 415 Ridgewood av., Glen Ridge
Sellitto, Anthony M., 115 Connett pl., South Orange
Sena, Marie A., 549 S. Orange av., Newark
Sevringhaus, Elmer L., 59 Warren pl., Montclair
Seward, William H., 188 S. Essex av., Orange
Shack, Maxwell H., 19 Lyons av., Newark
Shannon, James B., 66 S. Fullerton av., Montclair
Shannon, Lardner M., 66 S. Fullerton av., Montclair
Shapiro, Irving, 78 Clinton av., Newark
Shapiro, Louis, 146 Broad st., Newark
Shapiro, Ralph N., 1 Scotland road, South Orange
Shapiro, Samuel A., Army
Shaul, Frederick G., 10 Washington st., Bloomfield
Shaul, John F., Navy
Shaw, John J., 333 Beech Spring rd., South Orange
Shaw, Ned, Army
Shechner, Isadore, 244 Broadway, Newark
Sheehan, Daniel C., 535 Sanford av., Newark
Sherman, A. Russell, 671 Broad st., Newark
Sherman, Arthur E., Army

Sherman, Elbert S., 671 Broad st., Newark
Shill, Benjamin, 31 Lincoln Park, Newark
Shlionsky, Herman, 65 Church st., Montclair
Shor, David M., 32 S. Munn av., East Orange
Shreehan, Hubert F., 620 Summer av., Newark
Shulman, Murray W., 913 S. 20th st., Newark
Siegel, Jack G., 38 Johnson av., Newark
Siegel, Jacob W., 96 S. 10th st., Newark
Sieskind, Richard S., 1157 Clinton av., Irvington
Silberner, Herbert B., 299 Clinton av., Newark
Silverman, S. Andrew, 860 S. 11th st., Newark
Silverstein, Benj. J., 32 Hillside av., Newark
Silverstein, Jacob M., 73 Main st., Millburn
Simmons, Albert V., 720 Prospect st., Maplewood
Simms, George F., 541 Page av., Lyndhurst
Simon, Henry, 5 Vermont av., Newark
Simon, Ludwig L., 29 Hillside av., Newark
Simonson, Louis, 202 Osborne ter., Newark
Singer, Max, 147 Johnson av., Newark
Sisson, Nelson W., 144 Harrison st., East Orange
Siwek, Stanley, 331 Cleveland av., Harrison
Skwirsky, Joseph, 37 Randolph pl., Newark
Slavin, Paul, 31 Lincoln Park, Newark
Smalzried, Elmer W., 69 Woodland av., E. Orange
Smarzo, Marjorie M., 46 Vernon ter., East Orange
Smith, Byron J., 1041 S. Orange av., Newark
Smith, Charles H., 270 Ridgewood av., Glen Ridge
Smith, Christopher A., 43 Glen Ridge Pkw., Glen R.
Smith, Ellis L., Essex Co. Isolation Hosp., Belleville
Smith, Harold W., 179 Lincoln av., Orange
Smith, Henry G., Essex Co. Hosp., Cedar Grove
Smith, J. Meredith, 198 Valley rd., Montclair
Smith, Leonard H., 32 Washington st., East Orange
Smith, Thayer A., Forest dr., Short Hills
Snavely, Earl H., Newark City Hospital, Newark
Snook, Lee O., Jr., 8 Hedden ter., N. Arlington
Sobin, Julius, 24 Waverly av., Newark
Solk, Arthur G., 47 Lincoln Park, Newark
Solomon, Harold, 79 Shanley av., Newark
Somberg, Harold, 31 Lincoln Park, Newark
Somers, Fred L., 144 Harrison st., East Orange
Soschin, Samuel J., 31 Lincoln Park, Newark
Spallone, Joseph C., 123 Mt. Prospect av., Newark
Spence, Harold G., 205 Park st., Montclair
Sperling, Irving L., 62 Lyons av., Newark
Sperling, Walter, 29 Oxford st., Montclair
Spinner, Samuel L., 15 Third st., Elizabeth
Sprague, Edward W., 86 Washington st., Newark
Staehle, Richard H., 366 S. Orange av., S. Orange
Stahl, Alfred, 160 Lincoln av., Newark
Stahl, Charles, 659 Sanford av., Newark
Staknevich, John H., 658 Grove st., Irvington
Starr, George R., Jr., 665 Berkeley av., Orange
Statman, Arthur J., 17 Leslie st., Newark
Stearns, Thornton, 312 Harrison st., East Orange
Steiner, Edwin, 31 Lincoln Park, Newark
Steiner, Herbert, 350 Stuyvesant av., Irvington
Stern, Max E., 2 Milford av., Newark
Stern, Morton M., 24 Girard pl., Newark
Stevens, Merton H., 58 S. Maple av., East Orange
Stewart, Robert G., 79 Midland av., Montclair
Stickles, Lloyd C., 49 Parkhurst st., Newark
Stiles, C. Campbell, 713 Park av., East Orange
Stoddard, Gordon V., 96 Glenwood av., E. Orange
Stokes, Donald E., 120 Prospect st., South Orange
Stoll, George F., 330 Washington av., Belleville
Strack, Vincent J., 1072 S. Orange av., Newark
Straub, Herbert H., 242 Springdale av., East Orange
Straus, Max, 87 Harrison pl., Irvington
Strauss, Frederick, 845 S. 12th st., Newark
Strauss, Max, 190 Clinton av., Newark
Strauss, William T., Jr., 6 Jerome pl., UpperMontcl'r
Streen, Morris E., 908 Bergen st., Newark
Sturchio, Edoardo, 104 Ferry st., Newark
Sturchio, Eugenio, 178 Mt. Prospect av., Newark
Sutton, Joseph G., Essex Co. Hosp., Cedar Grove
Swain, Richard D., Jr., 211 Roseville av., Newark
Symes, Earl R., 544 Belgrove drive, Kearny
Szerlip, Leopold, 43 Shepard av., Newark
Szivos, Louis A., 160 Glenwood av., East Orange
Taff, Harry, 165 Roseville av., Newark
Taffet, William, 379 Union av., Belleville
Tansey, W. Austin, Jr., 169 Hobart av., Short Hills
Tarbell, Harold A., 13 Pennington st., Newark
Teeter, Charles E., 418 Orange st., Newark
Tenney, Albert S., 6 N. Munn av., East Orange
Thomas, John H., 270 Lenox av., South Orange
Thomison, Harry E., 605 Broad st., Newark
Thompson, Arthur F., 314 Oakwood av., Orange
Thomson, Carroll S., Fair Oaks Sana., Summit
Thornhill, Arthur C., 47 Forest st., Montclair
Thornley, William F., 495 Prospect st., Maplewood
Thum, Kurt W., 366 Main st., West Orange
Tillis, Herman H., 31 Lincoln Park, Newark
Tobey, Franklin J., 11 Hazelwood av., Newark
Tobey, John R., 11 Hazelwood av., Newark
Tocci, Frank, 74 Grove st., Montclair
Toczek, Heinrich A., 391 Bergen st., Newark
Tomeo, Richard F., 70 Harrison av., Montclair
Torppey, John J., 472 Sanford av., Newark
Trautwein, Charles F., 131 Nesbit ter., Irvington
Troedsson, Bror S., 188 S. Essex av., Orange
Tucker, Albert B., 47 Lincoln park, Newark
Tuly, Ralph, 134 S. Kingman rd., South Orange
Tunis, Benno B., 22 Ingraham pl., Newark
Turi, Amedeo E., 407 Mt. Prospect av., Newark
Turner, Charles F., 151 Grove st., Montclair
Tushnet, Leonard, 662 18th av., Irvington
Tutela, Arthur C., 220 S. Seventh st., Newark
Twitchell, Adelbert B., 162 S. Orange av., S. Orange
Tymeson, Walter R., 310 Main st., Orange
Ulan, Oscar, 92 Fleming av., Newark
Ulvestad, Lawrence E., 119 Irvington av., S. Orange
Urbach, George, 181 Chancellor av., Newark
Valentin, Irmgard, 131 Harrison st., East Orange
Vallario, Frank A., 333 Clifton av., Newark
Vander Veer, H. Garrett, 295 M'tgomery st., Bl'mf'd
Van Emburgh, George H., 575 Belgrove dr.,Arlingt'n
Van Gieson, Edward J., 71 Watsessing av., Bloomf'ld
Vannatta, George W., 226 N. Park st., East Orange
Van Ness, H. Roy, 444 Parker st., Newark
Verbeck, Geo. B., 20 Church av., Ballston Spa, N. Y.
Villanova, Ralph N., 266 S. Eighth st., Newark
Vincent, Nicholas F., 144 Harrison st., E. Orange
Virgilio, Anthony A., 87 S. Centre st., Orange
VonHofe, Frederick H., 75 Prospect st., E. Orange
Wagner, John, 48 Wilson av., Newark
Wakeley, William E., 144 Harrison st., East Orange
Waldron, Robert E., 699 Kearny av., Arlington
Walkenberg, Michael, 56 Clinton pl., Newark
Wallack, Charles A., 23 Treacy av., Newark
Walsh, Charles R., 95 W. Northfield av., Livingston
Walton, Ralph W., 102 Gates av., Montclair
Wambsganss, Magdalena, 44 Devine st., Newark
Wangner, William F., 1190 Broad st., Bloomfield
Ward, Chauncey P.,, 112 Chancellor av., Newark
Ward, Elisabeth B., 112 Chancellor av., Newark
Ward, Gertrude P., 41 Park pl., Bloomfield
Ward, William R., 112 Chancellor av., Newark
Ward, William R., Jr., 112 Chancellor av., Newark
Warner, Halsey F., 444 Central av., East Orange
Warner, William H. A., 444 Central av., EastOrange
Waterman, Samuel M., 41 Shanley av., Newark
Weber, Francis C., 286 Mt. Prospect av., Newark
Weeks, Norman E., 159 Christopher st., Montclair
Weinmann, Max H., 714 Scotland rd., Orange
Weinstein, Francis S., 857 S. 11th st., Newark
Weinstein, Leopold, 82 Lyons av., Newark

Weinstein, Morris W., 942 Sanford av., Irvington
Weiss, Louis, 519 Springfield av., Newark
Weiss, Mortimer H., 78 Clinton av., Newark
Weiss, Selma, 2 Stratford pl., Newark
Welkind, Allen A., 365 Osborne ter., Newark
Weller, Arthur, 19 Hillyer st., Orange
Wesson, Harrison R., 198 Valley rd., Montclair
Weston, Clifford G., 27 Woodland av., Glen Ridge
Wheeler, William K., 160 Fourth av., E., Roselle
Whelan, Edward P., 460 Franklin av., Nutley
White, Robert R., 144 Harrison st., East Orange
Wiener, David, 196 Weequahic av., Newark
Willan, Edward H., 74 S. Munn av., East Orange
Willey, F. Parker, 153 Roseville av., Newark
Williams, John J., 78 Walnut st., Newark
Willner, Albert, 18 Wilbur av., Newark
Willner, Irving, Army
Willner, Milton, 225 Renner av., Newark
Willner, Philip, 852 S. 11th st., Newark
Willson, James H., 144 Harrison st., East Orange
Wilson, John H., Jr., 85 Halsted st., East Orange
Winter, Egon W., 825 S. 10th st., Newark
Wolf, Raymond E., 251 Ridgewood av., Glen Ridge
Wolfe, Jacob S., 44 Watsessing av., Bloomfield
Wolfe, William W., 383 Mulberry st., Newark
Wood, E. LeRoy, 533 Mt. Prospect av., Newark
Woolf, Bernhardt H., 41 Hedden ter., Newark
Work, John L.. Mountainside Hosp., Montclair
Wort, Frederick J., 1080 Broad st., Newark
Wortman, Herb. M., 121 Buckingh'm rd., U. Montcl'r
Wrensch, Alexander E., 79 Valley rd., Montclair
Wright, Robert E., 55 S. Clinton st., East Orange
Wuerthele, Virginia E., 560 Mt. Prospect av.,Newark
Wujciak, Henry J., 193 Warwick st., Newark
Wurts, Margaret M., 27 Wellesley av., Up. Montclair
Wurzel, Milton, 2 Farley av., Newark
Wyatt, Joseph H., 135 Clinton av., Newark
Wyker, Arthur W., 57 Park pl., Bloomfield
Wynder, Alfred, 654 Lyons av., Irvington
Yablonsky, Max, 30 Shanley av., Newark
Yadkowsky, Emanuel, 637 High st., Newark
Yaguda, Asher, 61 Lincoln Park, Newark
Yankowicz, Michael, Army
Yates, Glen L., 270 Ridgewood av., Glen Ridge
Yelin, Gabriel, 635 High st., Newark
York, Jack S., 63 Baldwin av., Newark
Young, I. Henry, 220 Columbia av., Irvington
Young, John H., 37 N. Fullerton av., Montclair
Zacher, Andrew A., 685 High st., Newark
Zager, Saul, 31 Lincoln Park, Newark
Zehnder, A. Charles, 188 Roseville av., Newark
Zimmer, William, 1410 Maple av., Hillside
Zimmerman, Coler, 6 Colony dr., S., West Orange
Zingali, John A., 105 Glenridge av., Montclair
Zucker, Isadore, 112 Shanley av., Newark
Zukerberg, Nathan, 21 Johnson av., Newark
Zvaifler, Nathan, 46 Wilbur av., Newark
Zweibel, Leonard, 871 S. 11th st., Newark
Zweigel, Isidore, 22 Monticello av., Newark
Zybulewski, Edmund A., 410 Bergen st., Newark

ASSOCIATE MEMBERS

Alterbaum, George, 25 Park av., Caldwell
Amato, John R., 59 South st., Newark
August, Jacob, 149 Rhode Island av., East Orange
Becker, Sylvia F., 35 Leslie st., Newark
Bellucci, Frank D., 300 Mt. Prospect av., Newark
Bensel, Arlington, Jr., 6 N. Munn av., East Orange
Blasi, Benjamin, 150 Hunterdon st., Newark
Block, Charles, 368 Clinton av., Newark
Boyd, James W., 67 S. Munn av., East Orange
Brandchaft, Bernard, 658 Springfield av., Newark
Brill, Robert, 366 Peshine av., Newark
Bromberg, Jules H., 89 Lincoln Park, Newark
Burch, Reynold E., 5 Wallace st., Newark
Cacchioli, Louis G., 26 Dover st., Newark
Cassio, William L., 226 Norfolk st., Newark
Chromow, Bernard, 31 Lincoln Park, Newark
Cincotti, Victor F., 11 Hill st., Newark
Comando, Edward N., 695 Clinton av., Newark
Cooper, Jehu P., Army
Crater, Kenneth E., 24 Jersey st., Bloomfield
Crecca, Joseph V., Essex Mountain Sana., Verona
Culver, Perry, 53 Stratford st., West Roxbury, Mass.
DeLorenzo, Francis, 180 Walnut st., Montclair
Dmytriw, Stephen, 226 N. Park st., East Orange
Douglass, Frederick W., 160 Lincoln st., Montclair
Drewery, Robert E., Army
Eckhardt, Janet L., 120 Prospect st., South Orange
Edwards, Sydney K., 52 Lexington dr., Livingston
Evans, John R., Jr., 496 Prospect st., South Orange
Faln, Irving, 155 Chancellor av., Newark
Finkelstein, Aaron, 37 Aldine st., Newark
Fischman, Mervin, 264 Clinton pl., Newark
Gambacorta, Otto, 397 North 13th st., Newark
Gaydos, Albert, 225 Hillside av., Nutley
Gear, Phillip E. D., 340 Belmont av., Newark
German, Bernard, 89 Lincoln Park, Newark
Giannotto, Anthony S., Army
Gianquinto, Peter, St. Barnabas Hospital, Newark
Goodman, Stanley J., 89 Lincoln Park, Newark
Gras, Alfred E., 160 Roseville av., Newark
Greenfield, Sylvan J., 32 S. Munn av., East Orange
Grubin, Charles J., 1224 Salem av., Hillside
Gurian, Sydney H., 262 Seymour av., Newark
Hanfling, Seymour L., 115 S. Munn av., East Orange
Hermann, John H., Jr., 197 S. Centre st., Orange
Holder, Lester, 29 S. Munn av., East Orange
Hyde, Robert T., 46 Maple st., Millburn
Hyland, Michael, 197 Kearny av., Kearny
Iannone, Angelo B., 659 Park av., East Orange
Insabella, John, 317 S. Orange av., Newark
Israel, Joseph, 252 Washington av., Belleville
Judge, Thomas V., Jr., 514 Mt. Prospect av., Newark
Kawalek, Roman, 46 S. Burnett st., East Orange
Kenny, James, 392 Tremont av., Orange
Keyssar, Alexander, 18 Isabella av., Newark
Kimche, Irwin, 27 Rawley pl., Millburn
Klein, Michael, Veterans Administration, Newark
LaCaille, Rupert A., 178 Spruce st., Newark
Leon, Jerome L., 89 Lincoln Park, Newark
Leon, Maurice J., 387 U. Mountain av., U. Montclair
Livingston, Elias, 591 Stuyvesant av., Irvington
Lombardo, Bartlo, 111 Wilson av., Newark
Mancusi-Ungaro, Harold, 25 Oakland ter., Newark
Mason, John T., Jr., 118 Young av., Cedar Grove
McCroskery, Hamilton M., 471 N. Arlington av.,E.Or.
Merk, Anthony, 79 N. Ninth st., Newark
Murphy, Arthur G., 454 Park st., Upper Montclair
Murray, Edward F., 575 Highland av., Newark
Nelson, Clifford H., Army
Novak, John G., 111 Clinton av., Newark
Ott, Franklin B., Army
Panzer, Norman, 615 High st., Newark
Pasquale, Thomas L., 92 High st., Orange
Pedicini, Joseph L., 588 S. Tenth st., Newark
Perlman, Maximillan, 81 Lyons av., Newark
Perr, Herbert M., 239 Shepherd av., Newark
Pilpel, Michael, 82 Lyons av., Newark
Pogue, Elbert H., 539 High st., Newark

Rath, Morris, 140 Fourth av., East Orange
Ritota, Michael C., 85 Stuyvesant av., Newark
Rocco, John, 729 Summer av., Newark
Rubin, Sidney, 170 Hawthorne av., Newark
Russomanno, Paul, 212 Clifton av., Newark
Sandford, Francis R., 30 Academy rd., Caldwell
Santangelo, Joseph A., 218 Grafton av., Newark
Sarno, Anthony, 130 Parker st., Newark
Schaaf, Royal S., 53 Stratford st., W. Roxbury,Mass.
Schwartzfeld, Hyman, 301 Stuyvesant av., Newark
Scudese, Vincent A., 144 Ridge st., Newark
Shapiro, Sydney H., 334 Union st., Irvington
Sharlin, Herbert S., 745 S. Tenth st., Newark
Siegel, Leo, 132 Grumman av., Newark
Smith, Alan L., 32 Washington st., East Orange
Sobol, Herman, 205 Roseville av., Newark
Sparks, Spurgeon, Jr., 210 Oakwood av., Orange
Strazza, John A., 183 Broad st., Bloomfield
Svenson, Sven E., 515 Sanford av., Newark
Taffet, Seymour, 55 W. Passaic av., Bloomfield
Taterka, Adrian, 37 Fulton st., Newark
Travers, Frank A., 485 Park av., Orange
VanAmberg, Robert J., 85 Harrison st., East Orange
Vernon, Leonard J., 175 Central av., Orange
Wakeley, William E., Jr., 144 Harrison st., E. Orange
Waldron, John F., 9 Mayhew dr., South Orange
Wannamacher, Paul, 173 Maple st., West Orange
Warnecke, Rudolph E., 43 S. Maple av., East Orange
Weinberg, C. Richard, 585 Clinton av., Newark
Weiss, Fred, 254 Wainwright st., Newark
Whigham, Herbert H., Jr., 38 Madison av., Montclair
Wortman, Harry C., Jr., 15 Washington st., Newark

HONORARY MEMBERS

Baird, Thompson M., Pt. Pleasant
Baldwin, Samuel H., South Orange
Bleick, Theodore E., Newark
Chamberlain, Aims R., Maplewood
McBride, Hesser G., East Orange
Morrison, Caldwell, South Orange
Price, Nathaniel G., Newark
Smith, Joseph J., Newark

GLOUCESTER COUNTY (8)

Society organized December, 1818. Regular meetings on third Thursday of each month, except June, July and August. Annual Meeting in May. Annual Social Session in October.

ACTIVE MEMBERS

Black, Maskell B., 128 E. High st., Glassboro
Bowersox, Clarence A., 509 N. Broad st., Woodbury
Brewer, David R., Jr., 112 N. Broad st., Woodbury
Brower, Francis M., III, 62 E. Center st., Woodbury
Burkett, Wendell J., 16 W. Holly av., Pitman
Campo, Salvatore T., Army
Chalfant, William P., Br'dway & Crafton av.,Pitman
Collins, Louis K., 54 State st., Glassboro
DiMarino, Anthony J., 735 Delaware st., Paulsboro
Faux, Frederick J., 32 N. Columbia st., Woodbury
Fisler, Charles F., 140 Maple st., Clayton
Fooder, Horace M., 110 Main st., Williamstown
Hollinshed, Ralph K., 351 Broadway, Westville
Hughes, Joseph F., 16 N. Broad st., Woodbury
La Rosa, Frank J., 316 N. Broadway, Pitman
Lintz, Sidney Z., 525 Kings Highway, Swedesboro
Livengood, Baxter A., 64 Cooper st., Woodbury
Moore, Ralph L., 127 N. Broad st., Woodbury
Patterson, Isaac N., 230 Broadway, Westville
Pedrick, William W., 11 West st., Glassboro
Pegau, Paul M., 246 Briar Hill lane, Woodbury
Rhoads, S. Creadick, 104 Station av., Westville
Rogers, Dorothy M., 50 Cooper st., Woodbury
Serri, William S., 447 Kings Highway, Swedesboro
Sheets, Cecil C., 213 W. Broad st., Paulsboro
Sherman, Fuller G., 204 Delaware st., Woodbury
Sinexon, Henry L., 36 W. Broad st., Paulsboro
Stewart, Irving J., 529 Kings Highway, Swedesboro
Ulmer, Chester I., 431 W. Broad st., Gibbstown
Underwood, J. Harris, 509 N. Broad st., Woodbury
Venturo, Ralph C., 62 Hunter st., Woodbury
Wandall, Frederick G., 50 E. High st., Clayton
Weems, Don B., 105 E. Mantua av., Wenonah
Wentzell, J. Earl, 5 E. Mantua av., Wenonah
Whitaker, Henry J., 10 S. Broadway, Pitman
Wright, Herman W., 818 S. Broadway, Pitman
Zahn, Jack R., 90 Paterson av., Gibbstown

HUDSON COUNTY (9)

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, meeting to be held on next day. Annual Meeting in May.

ACTIVE MEMBERS

Abarbanel, Milton G., 160 W. 31st st., Bayonne
Africano, Julius V., 43 Columbia ter., Weehawken
Agolia, Michael W., 2201 Palisade av., Union City
Ainsley, H. Bryson, 246 Union st., Jersey City
Albini, Mario J., 204 Fifth st., Hoboken
Alpert, Edward, 661 Jersey av., Jersey City
Alter, Nicholas M., 410 Fairmount av., Jersey City
Amdur, Louis A., 2540 Boulevard, Jersey City
Angelo, Joseph A., Bank Bldg., Secaucus
Annitto, John E., 170 Belmont av., Jersey City
Anrig, Grace E., 613 Summit av., Union City
Arbeit, Sidney R., 56 Gifford av., Jersey City
Arena, John, 9209 Boulevard, North Bergen
Aria, Charles J., 1818 Boulevard, Jersey City
Aria, Michael H., 31 Glenwood av., Jersey City
Arndt, Frank R., 7500 Bergenline av., North Bergen
Aronoff, Herman L., 225 Claremont av., Jersey City
Aronowitz, Harry T., 923 Avenue C, Bayonne
Artaserse, George V., 185 Bergen av., Jersey City
Ash, Arthur F., 710 Boulevard, E., Weehawken

Atwell, David R., 920 Hudson st., Hoboken
Auriémma, Michele, 419 Adams st., Hoboken
Aymar, Dorothy, 608 Fourth st., Union City
Bahnson, Conrad M., 170 Bowers st., Jersey City
Bailyn, Emanuel, 400 60th st., West New York
Baldini, Charles F., Jr., 513 15th st., Union City
Balsamo, Anthony J., 5016 Hudson av., W.NewYork
Barbarito, William N., 135 Bentley av., Jersey City
Barishaw, Samuel B., 25 Bentley av., Jersey City
Barone, Francis A., 94 Lembeck av., Jersey City
Bedrick, John J., 945 Avenue C, Bayonne
Behrens, Herman H. E., 312 Webster av., Jer. City
Ben-Asher, Solomon, 61 Gifford av., Jersey City
Benjamin, Harold C., 59 Crescent av., Jersey City
Bergmeyer, Josef T., 6500 Palisade av., W. N. Y.
Berlin, Joseph I., 2600 Boulevard, Jersey City
Berlin, Walter, 2600 Boulevard, Jersey City
Bigliani, Urban R., 606 80th st., North Bergen
Blakey, Abram P., 157 Wegman Pkwy., Jersey City
Bookrajian, Edward N., 8027 Boulevard, N. Bergen
Borchek, Arthur R., 7610 Broadway, No. Bergen
Borrone, Milton G., 2624 Boulevard, Jersey City
Borshaw, Hyman, 108 Bentley av., Jersey City
Bortone, Frank, 2765 Boulevard, Jersey City
Boselli, Emile H., 614 15th st., Union City
Botti, John A., 236 Summit av., Jersey City
Boyers, Sidney S., 413 60th st., West New York
Boylan, Matthew E., 569 Pavonia av., Jersey City
Boyle, Francis L., 805 Boulevard, Bayonne
Bradasch, George A., 1415 Central av., Union City
Brady, Thomas S., 678 Avenue C, Bayonne
Braitman, Max, 412 60th st., West New York
Brauer, Charles, 2154 Boulevard, Jersey City
Brauer, Selig L., 2012 Boulevard, Jersey City
Braunstein, Sigmund C., 424 57th st., W. New York
Braunstein, William P., 1 Bellevue st., Weehawken
Brennock, Thomas McG., 3 Webster av., Jersey City
Brick, George J., 43 Cottage st., Jersey City
Brozdowski, John J., 562½ Jersey av., Jersey City
Butler, Vincent P., 33 Bentley av., Jersey City
Campana, Vincent R., 386 Fairm'nt av., Jersey City
Cangemi, Vito F., 50 Glenwood av., Jersey City
Cannon, Edward A., 7512 Boulevard, North Bergen
Caridi, Salvatore, 431 59th st., West New York
Carr, Mary B., 1 Astor pl., Jersey City
Casciano, Adolph D., 189 Harrison av., Jersey City
Catlaw, J. Kenneth, 254 Montgomery st., Jersey City
Chapman, Ellis J., 203 Danforth av., Jersey City
Chapman, Walter I., 700 Avenue C, Bayonne
Chayes, Sydney, 980 Avenue C, Bayonne
Chieffo, Henry, 387 Hoboken av., Jersey City
Christian, Henry A., 111 Fairview av., Jersey City
Cieri, Daniel S., 1515 Central av., Union City
Cohen, Herman, 489 Jersey av., Jersey City
Cohen, Samuel, 100 Clifton pl., Jersey City
Cohen, Samuel A., 980 Summit av., Jersey City
Comora, Herman C., 317 60th st., West New York
Connell, Emmet J., 2227 Boulevard, Jersey City
Connolly, Thomas W., 921 Bergen av., Jersey City
Conty, Anthony J., 318 48th st., Union City
Corless, Joseph F., 5503 Palisade av., West New York
Cosgrove, Robert A., 186 Belmont av., Jersey City
Cosgrove, Samuel A., 88 Clifton pl., Jersey City
Costa, George J., 567 Jersey av., Jersey City
Cracco, Frederick A., 211 Palisade av., Union City
Cricco, Carl F., 909 Washington st., Hoboken
Cufari, Carmine J., 725 18th st., Union City
Cziraky, Anton, 516 34th st., Union City
D'Acierno, Pellegrino A., 1708 Pallsade av., UnionC'y
Daly, Edmund J., 921 Bergen av., Jersey City
Danielson, John J., 4703 Tonnele av., No. Bergen
Dasher, William A., 269 Jewett av., Jersey City
Davis, Daniel, Army
De Fusco, G. Thomas, 330 Newark av., Jersey City
Deitmaring, Francis A., 7922 Boulevard, N. Bergen
DeMarco, Silverino V., 2554 Boulevard, Jersey City
DePietro, Vincent P., 520 48th st., Union City
De Rosa, Louis, 193 Danforth av., Jersey City
Dershewitz, Irving, 835 Montgomery st., Jer. City
DeSevo, Gerard E., 108 Fairview av., Jersey City
Detrano, Salvatore J., 903 Washington st., Hoboken
DeVincenzo, F. Richard, 629 Wash'gton st.,Hobok'n
Dexter, Harriet E. T., 903 Avenue C, Bayonne
DiGioia, John, 287 Pacific av., Jersey City
Dolganos, Moses, 268 Palisade av., Jersey City
Donnelly, Joseph P., 58 Kensington av., Jersey City
Donohoe, Lucius F., 140 W. Eighth st., Bayonne
Donohue, Daniel J., 139 Highland av., Jersey City
Doody, William M., 19 Bentley av., Jersey City
Doran, Ralph J., 200 11th st., Hoboken
Doran, William G., 2685 Boulevard, Jersey City
Dougherty, Daniel D., 1218 Bloomfield st., Hoboken
Duckett, Warren J., 21 Carlton av., Jersey City
Dukes, Howard R., 220 Kearny av., Kearny
Edelstein, Isidore, 938 Hudson st., Hoboken
Edwards, Lena F., 358 Pacific av., Jersey City
Elsasser, Theodore H., 7206 Park av., Woodcliff
Elwood, Benjamin J., 810 Boulevard, Bayonne
Enright, James G., 25 Kensington av., Jersey City
Ettinger, Samuel, 501 32nd st., Union City
Evans, J. Lawrence, 7117 Park av., Woodcliff
Faber, Edward, 154 Bergen av., Jersey City
Fabriele, John B., 1112 Boulevard, Bayonne
Facciolo, Frank, 562 Boulevard, Bayonne
Faison, John B., 45 Glenwood av., Jersey City
Fattel, Henry C., 8300 Boulevard, North Bergen
Fauquier, Leonard B., 172 Jewett av., Jersey City
Federer, John J., 69 Columbia ter., Weehawken
Feinberg, Harry, 807 Avenue A, Bayonne
Feldman, Morris, 51 Bentley av., Jersey City
Feller, William, 283 Bergen av., Jersey City
Fialk, Harry, 337 52nd st., West New York
Ficke, Sylvia A., 906 Summit av., Jersey City
Fifer, William T., 746 Avenue C, Bayonne
Figurelli, Francis A., 88 Highland av., Jersey City
Finger, Frederick A., 943 Avenue C, Bayonne
Finke, Charles H., 317 York st., Jersey City
Finkelstein, Max, 3258 Boulevard, Jersey City
Finn, Frederick A., 921 Bergen av., Jersey City
Finn, Henry R. W., 84 Lembeck av., Jersey City
Fischer, Leo E., 70 Sherman pl., Jersey City
Flichtenfeld, Morris, 283 4th st., Jersey City
Fliegel, Hilda C., 309 Baldwin av., Jersey City
Frank, Herman I., 98 W. 35th st., Bayonne
Frank, Morris, 920 Avenue C, Bayonne
Frank, Nathan, 180 Bowers st., Jersey City
Franklin, I. Harold, 191 Palisade av., Jersey City
Freyberger, George A., 85 Columbia ter., Weehawken
Freymann, Walter, 5006 Hudson av., W. New York
Frieman, Hyman, 744 Avenue C, Bayonne
Garbarini, John G., 907 Summit av., Jersey City
Garibaldi, Louis J., 1018 Hudson st., Hoboken
Gerne, Timothy A., 972 Summit av., Jersey City
Gerner, Harry E., 2627 Boulevard, Jersey City
Ghee, Euclid P., 115 Claremont av., Jersey City
Giannasio, Joseph, 461 Wayne st., Jersey City
Ginsberg, George, 624 Bloomfield st., Hoboken
Gleeson, William J., 640 Bergen av., Jersey City
Gnassi, Angelo M., 130 Wegman Parkway, Jer. City
Goldman, David L., 42 W. 22nd st., Bayonne
Goldowsky, Ira, 23 Warner av., Jersey City
Goldsmith, Alfred S., 8129 Boulevard, North Bergen
Good, Richard, 4619 Park av., Union City
Goodrich, Stewart L., 812 Avenue C, Bayonne
Gordon, Isaac L., 1815 Boulevard, Jersey City
Granelli, Humbert A., 213 Garden st., Hoboken
Greenberg, Philip, 1919 Boulevard, Jersey City
Greene, Albert D., 915 Pallsade av., Union City

Grieco, Emil H., 196 Broadway, Bayonne
Grossman, Rubin, 377 Avenue C, Bayonne
Grubowski, Joseph N., 562½ Jersey av., Jersey City
Gurland, Benjamin B., 146 W. 37th st., Bayonne
Gurley, Katharine A., 2671 Boulevard, Jersey City
Gutmann, Erwin K., 3258 Boulevard, Jersey City
Haggerty, Francis F., 724 Hudson st., Hoboken
Halligan, Earl J., 254 Montgomery st., Jersey City
Halperin, David, 590 Bergen av., Jersey City
Halpern, Sophia L., 1311 Palisade av., Union City
Handler, Harry, 305 York st., Jersey City
Harter, Louis F., 174 Bowers st., Jersey City
Hartwell, H. Ameroy, 777 Boulevard, E., Weeh'wk'n
Harvey, John W., 818 Avenue C, Bayonne
Harz, William V., 880 Avenue C, Bayonne
Hasking, Arthur P., 318 Montgomery st., Jersey City
Hauptman, Harry, 88 Sherman pl., Jersey City
Heilbrunn, Julius, 2540 Boulevard, Jersey City
Hernandez, Manuel, 1974 Boulevard, Jersey City
Herradora, Juan R., 2750 Boulevard, Jersey City
Hershey, Harry H., 921 Bergen av., Jersey City
Higgins, Gerald L., 283 Bergen av., Jersey City
Higgins, John T., 145 Highland av., Jersey City
Higgins, Thomas A., 2616 Boulevard, Jersey City
Hillel, Joseph, 325 74th st., North Bergen
Holland, Moses H., 2412 Palisade av., Weehawken
Horowitz, Alexander S., 4614 Boulevard, Union City
Horowitz, Leo, 3644 Boulevard, Jersey City
Howeth, John L., 14 Duncan av., Jersey City
Huss, Louis, 4313 Bergenline av., Union City
Imhoff, John G., 913 Summit av., Jersey City
Introcaso, Dominick A., 45 Crescent av., Jersey City
Irving, Henry C., 27 Warner av., Jersey City
Jaffe, Benjamin, 566 Bergen av., Jersey City
Jaffe, Herman M., 2600 Boulevard, Jersey City
Jaffin, Abraham E., 41 Emory st., Jersey City
Jaksch, Maria, 137 Arlington av., Jersey City
Jaques, J. Eugenia, 74 Waverly st., Jersey City
Jentz, John H., 67 Sherman pl., Jersey City
Johnson, Archie W., 169 Claremont av., Jersey City
Jones, Clement M., 454 Boulevard, Bayonne
Jones, J. Morgan, Valley rd., Oakland
Joseph, Benjamin M., 2771 Blvd., Jersey City
Judy, Kenneth H., 26 Journal Square, Jersey City
Justin, Arthur W., 41 Fulton st., Weehawken
Kainer, Herbert, 4411 Boulevard, North Bergen
Kanengiser, Clifford H., 26 Gifford av., Jersey City
Kaplan, Herman B., 324 44th st., Union City
Katz, Jacob D., 38 Bentley av., Jersey City
Katz, Sidney, 8116 Boulevard, North Bergen
Keegan, Thomas D., 8 Gifford av., Jersey City
Keeney, James C., 1201 Park av., Hoboken
Keller, Rudolph J., 821 Garden st., Hoboken
Kelly, Bernard S., 1954 Boulevard, Jersey City
Kelly, Harry R. J., 14 49th st., Weehawken
Kennedy, John W., 414 61st st., West New York
Kiely, Eugene M., 800 Hudson st., Hoboken
Kimmel, M. Leonard, 3342 Boulevard, Jersey City
Klein, Allen, 8628 Boulevard, North Bergen
Klein, Julius, 1513 Palisade av., Union City
Kolb, John M., 1611 Boulevard, North Bergen
Kooperstein, Samuel I., 60 Reservoir av., Jersey City
Kornfield, Norman B., 24 Clinton av., Arlington
Kraemer, Samuel H., 309 Baldwin av., Jersey City
Kraut, Arthur M., 25 Gifford av., Jersey City
Kresch, Philip, 86 W. 34th st., Bayonne
Kuhlmann, Alvin E., 527 37th st., Union City
Kun, Bertram, 135 Belmont av., Jersey City
Kurtz, Geza R., 116 Fairview av., Jersey City
Lakiszak, Roman T., 162 Harrison av., Jersey City
Landshof, Charles A., 50 Glenwood av., Jersey City
Lane, Thomas F., 145 Garrison av., Jersey City
Lange, Louis C., 50 Clifton ter., Wechawken
Largay, Arthur O., 337 Avenue C, Bayonne
Lawsing, G. Conde, 443 66th st., West New York
Lee, William A., 447 West Side av., Jersey City
Leir, J. Krevin, 2787 Boulevard, Jersey City
Lempke, Richard J., 3 Armstrong av., Jersey City
Lepis A. Albert, 85 Jewett av., Jersey City
Levine, G. Irving, 100 Bentley av., Jersey City
Lieberson, Leonard, 20 62nd st., West New York
Linden, Mortimer H., 45 Clendenny av., Jersey City
Lindroth, Lawrence V., 4633 Boulevard, N. Bergen
Lipshutz, Charles, 820 Avenue C, Bayonne
Lisanti, Gaetano, 6109 Monroe pl., West New York
Little, Alonzo W., 120 Arlington av., Jersey City
Lobban, Robert B., 2595 Boulevard, Jersey City
Londrigan, Joseph F., 832 Bloomfield st., Hoboken
Londrigan, Joseph F., II, 832 Bloomfield st.,Hoboken
Long, Miles T., 2150 Boulevard, Jersey City
Luczynski, Edward W., 726 Avenue C, Bayonne
Lupin, Edward E., 930 Boulevard, Bayonne
Lynch, Roland J., Mental Diseases Hosp., Secaucus
Lynn, Irving I., 2760 Boulevard, Jersey City
Macchia, Benjamin J., 358 Arlington av., Jersey City
Machkowsky, Edwin, 241 Second st., Jersey City
Mackin, John J., 596 Bergen av., Jersey City
Madaras, John S., 870 Avenue C, Bayonne
Madison, L. Keith, 358 Pacific av., Jersey City
Malinowski, John, 554½ Jersey av., Jersey City
Manette, Milton, 535 41st st., Union City
Marcus, Kurt, 85 Bowers st., Jersey City
Markowitz, Benjamin B., 116 Gifford av., Jersey City
Markowitz, Irwin B., 2157 Boulevard, Jersey City
Marrella, Louis F., 101 Lafayette st., Jersey City
Marshall, Frank A., 2202 Palisade av., Weehawken
Masiello, Carmine J., 1200 Central av., Union City
Mastromonaco, Joseph D., 790 Avenue C, Bayonne
Mathesheimer, Jacob L., 280 Old Bergen rd., Jer.C'y
Mathews, William J., 938 Hudson st., Hoboken
Matturri, Dominick A., 81 Gifford av., Jersey City
Maver, William W., 532 Bergen av., Jersey City
McCarron, James A., 341 Avenue A, Bayonne
McCarthy, John J., 1001 79th st., North Bergen
McGovern, Patrick J., 26 Carlton av., Jersey City
McKeever, William J., 990 Summit av., Jersey City
McLean, Hugh A., 414 61st st., West New York
McLoughlin, Frank J., 558 Jersey av., Jersey City
McLoughlin, John W., 34 W. 32nd st., Bayonne
McNenney, Claudio E., 113 Fairview av., Jersey City
Meehan, George E., 117 Mercer st., Jersey City
Meltsner, Louis, 904 Hudson st., Hoboken
Meltzer, Louis, 837 Avenue C, Bayonne
Mersheimer, Christian H., 15 Reservoir av.,JerseyC'y
Meyer, William, 2128 New York av., Union City
Meyerson, Noah, 428 59th st., West New York
Mickewich, Stephen A., 817 Avenue C, Bayonne
Miller, Max H., 311 60th st., West New York
Miller, Robert B., Navy
Miranti, Paul J., 2685 Boulevard, Jersey City
Modarelli, Walter H., 1505 Central av., Union City
Monfort, Robert N., 650 Bergen av., Jersey City
Monica, Louis A., 875 Boulevard, Bayonne
Moriarty, John F., 723 Washington st., Hoboken
Morley, Grace C., 64 Clifton ter., Weehawken
Morris, David G., 11 W. 26th st., Bayonne
Muccia, John J., 7 Tonnele av., Jersey City
Mueller, George H., 102 Summit av., Jersey City
Mulvihill, William J., 275 Boulevard, Bayonne
Murphy, James M., 2757 Boulevard, Jersey City
Murphy, Leo J., 1814 West st., Union City
Murphy, Patrick H. W., 27 Jefferson av., Jersey City
Murray, Joseph A., 765 Avenue C, Bayonne
Mustermann, Otto H., 303 48th st., Union City
Muttart, George W., 2521 Boulevard, Jersey City
Mutter, Alfred A., 75 Beech st., Arlington
Nafash, Shafeek, 1117 16th st., North Bergen

Nalitt, David I., 28 W. 33rd st., Bayonne
Nevins, Thomas F., Jr., 23 Edwards ct., Bayonne
Nicholson, Frank P., 895 Summit av., Jersey City
Nobile, James J., 913 Hudson st., Hoboken
Norton, James F., 58 Kensington av., Jersey City
Ockene, Abraham, 2415 Palisade av., Union City
Oesterreicher, Desider, 427 Bergen av., Jersey City
O'Hanlon, George, Medical Center, Jersey City
Olpp, Arch. E., 1516 Bergenline av., Union City
Ortolano, James J., 911 Washington st., Hoboken
O'Shea, John J., 2200 Palisade av., Weehawken
Oshrin, Henry, 7500 Bergenline av., North Bergen
Padney, Edward V., 452 Jersey av., Jersey City
Pagliughi, John J., 1915 Palisade av., Union City
Pearlstein, Frank, 325 60th st., West New York
Peckman, Abram, 2511 Boulevard, Jersey City
Penchansky, Samuel J., 847 Avenue C, Bayonne
Pentel, Louis S., 307 60th st., West New York
Perkel, Louis L., 2801 Boulevard, Jersey City
Perlberg, Harry J., 921 Bergen av., Jersey City
Peters, Edgar A. P., 394 Bergen av., Jersey City
Peterson, Charles A., 921 Washington st., Hoboken
Piltz, George F., 153 69th st., Guttenberg
Pindar, Frederick S., 7500 Park av., Woodcliff
Plavin, Nathan J., 8010 Boulevard, North Bergen
Pollak, Berthold S., 100 Clifton pl., Jersey City
Pontery, Herbert B., 89 Bowers st., Jersey City
Potter, Benjamin P., 100 Clifton pl., Jersey City
Povalski, Alex. W. T., 1925 Boulevard, Jersey City
Price, H. Preston, 317 Hamilton rd., Ridgewood
Prince, Samuel, 7702 Park av., North Bergen
Purdy, Charles H., 35 Highland av., Jersey City
Pusin, Max, 100 Clifton pl., Jersey City
Quaglieri, Charles L., 733 Park av., Hoboken
Quigley, Frederic J., 543 45th st., Union City
Quinn, John J., 921 Bergen av., Jersey City
Raso, Frank L., 1218 Central av., Union City
Read, Donald B., 105 Hudson st., Jersey City
Reznikoff, Leon, Hudson Co. Mental Hosp.,Secaucus
Ricciardelli, Emmanuel F., 1670 Boulevard, Jer. City
Rieman, Aloysius P., 3566 Boulevard, Jersey City
Riese, Jacob A., 6012 Palisade av., West New York
Rosen, Charles E., 211 Palisade av., Union City
Rosenberg, Jacob, 692 Bergen av., Jersey City
Rosenstein, Jacob L., 568 Bergen av., Jersey City
Rossi, John R., 119 W. 36th st., Bayonne
Rubenstein Eli, 783 Avenue C, Bayonne
Rubensteln, Robert, 2758 Boulevard, Jersey City
Ruffer, Ralph A., 619 15th st., Union City
Rundlett, Emilie V., 79 Prospect st., Jersey City
Ruoff, Andrew C., 2414 New York av., Union City
Ruvane, Joseph J., 2787 Boulevard, Jersey City
Sabini, Cecil F., 603 Jefferson st., Hoboken
Sacco, Anthony G., 2200 New York av., Union City
Sachs, Fred, 48 Warner av., Jersey City
Sachs, Wilbert, 921 Bergen av., Jersey City
Sager, Harold, 19 W. 22nd st., Bayonne
Sakowski, John P., 20 W. 22nd st., Bayonne
Saladino, Anthony J., 427 15th st., Union City
Salmon, Edward F., 50 Gifford av., Jersey City
Salzmann, Bertold, Margaret Hague Hosp., Jer. City
Santosky, Benjamin B., Army
Saradarian, Albert V., 2401 New York av., Union City
Scala, H. Albert, 41 Madison av., Jersey City
Schapiro, Morris, 800 Avenue C, Bayonne
Schenker, Benjamin N., 246 Fifth st., Jersey City
Schenker, Israel N., 3697 Boulevard, Jersey City
Schenker, Sarah S., 1009 Garden st., Hoboken
Schept, Samuel S., 523 37th st., Union City
Schimenti, Matteo, 1893 Boulevard, Jersey City
Schlein, August, 707 Park av., Hoboken
Schneckendorf, Samuel J., 179 Harrison av., Jer. City
Schnelder, Louis A., 412 61st st., West New York
Schuchner, William F., 550½ Jersey av., Jersey City
Schuck, Traugott J., 58 Ninth st., Hoboken
Schwartz, Harold B., 47 Duncan av., Jersey City
Schwartz, Lewis, 2695 Boulevard, Jersey City
Schwarz, Berthold T. D., 2787 Boulevard, Jersey City
Schwarz, John, 50 Hauxhurst av., Weehawken
Sciarrillo, Louis F., 105 Newark st., Hoboken
Sciorsci, Edward F., 609 Bloomfield st., Hoboken
Sciorsci, Mario, 609 Bloomfield st., Hoboken
Scott, John J., 6 Zerman pl., Weehawken
Scott, Samuel G., 141 Bergen av., Jersey City
Sheeran, Vincent J., 101 Bentley av., Jersey City
Shepard, Myron, 435 60th st., West New York
Sherman, Abraham, 68 Clifton ter., Weehawken
Shook, Benjamin E., 284 Bergen av., Jersey City
Shulman, Nathan L., 538 45th st., Union City
Siegel, Lester, 180 Belmont av., Jersey City
Silich, Robert L., 875 Boulevard, E., Weehawken
Silon, Milton R., 907 Washington st., Hoboken
Silvera, Salomon, 532 Bergen av., Jersey City
Simeone, Peter A., 138 Clerk st., Jersey City
Simpson, David B., 818 Avenue C, Bayonne
Singer, Sina S., 3443 Boulevard, Jersey City
Sinnott, Gerald W., Medical Center, Jersey City
Smith, Arthur B. R., Navy
Smith, Meyer, 14 Webster av., Jersey City
Spano, Frank, 320 47th st., Union City
Spath, William H., 722 Hudson st., Hoboken
Spohn, Eugene L., Navy
Sprague, Seth B., 301 York st., Jersey City
Starr, Benjamin, 96 Sherman pl., Jersey City
Stefansin, Frank, 1601 Boulevard, North Bergen
Stein, Albert, 600 80th st., North Bergen
Stein, Jacob M., 68 Columbia ter., Weehawken
Stockfisch, Robert H., 3637 Boulevard, Jersey City
Stokes, Anthony T., 819 First st., Secaucus
Stuart, William C., 1 Newark st., Hoboken
Sussman, Harold, 1122 Garden st., Hoboken
Swiney, Merrill A., III, 325 Avenue C, Bayonne
Taft, Herman L., 4605 Boulevard, North Bergen
Talty, John C., 935 Washington st., Hoboken
Tannert, Carl H., 331 77th st., North Bergen
Tataryan, Hovsep, 2024 New York av., Union City
Temes, J. Howard, 9 Garrison av., Jersey City
Terwedow, Henry, 7707 Boulevard, North Bergen
Terwedow, Walter G., 518 79th st., North Bergen
Thomas, Ralph B., 793 Montgomery st., Jersey City
Tidwell, Harold F., 229 60th st., West New York
Timlin, James W., 64 Beech st., Arlington
Troum, Nathan, 82 Danforth av., Jersey City
Tsucalas, James C., 753 Montgomery st., Jersey City
Tyndall, Hugh H., 83 Highwood ter., Weehawken
Urevitz, Abraham, 2415 New York av., Union City
Utkewicz, Edmond A., 2633 Boulevard, Jersey City
Varriano, John L., 3263 Boulevard, Jersey City
Vespignani, Pasquale, 863 Montgomery st., Jer. City
Visceglia, Frank R., 430 74th st., North Bergen
Visconti, Joseph A., 105 Newark st., Hoboken
Viti, Henry A., 274 Barrow st., Jersey City
Vostrosablin, Nicholas A., 121 Grand st., Jersey City
Wager, Henry P., 39 Gifford av., Jersey City
Wallack, Eli A., 92 Fairview av., Jersey City
Waters, Edward G., 39 Gifford av., Jersey City
Watman, Anthony J., 2784 Boulevard, Jersey City
Weber, Laura E., 305 23rd st., Union City
Weber, Walter D., 305 23rd st., Union City
Weisman, Herbert, 273 Avenue A, Bayonne
Weiss, Morris J., 734 Avenue C, Bayonne
Wheeler, James A. V., 85 VanReypen st., JerseyCity
White, Hugh M., 901 Summit av., Jersey City
White, Thomas J., 50 Glenwood av., Jersey City
Wichman, Heins, 2672 Boulevard, Jersey City
Wilcox, Frank A., 329 60th st., West New York
Woelfle, Henry E., 907 Summit av., Jersey City
Wolbert, Charles M., Army

Yanowitz, Bernard, 135 Bergen av., Jersey City
Yeaton, William L., Jr., 204 11th st., Hoboken
Yontef, Reuben, 851 Avenue C, Bayonne
Yudkoff, William, 770 Avenue A, Bayonne
Zampella, Arthur, 921 Bergen av., Jersey City
Zbar, Joseph E., 2690 Boulevard, Jersey City
Zitani, Alfred M., 937 Washington st., Hoboken
Zuckerberg, Irving, 800 Avenue C, Bayonne

HONORARY MEMBERS

Connell, John, Jersey City
Gille, Hugo, Jersey City
Older, Benjamin, Union City
Fyle. Wallace, Jersey City
Rosecrans, James H., Hoboken
Sexsmith, George W., Los Angeles, California
Smith, Alexander L., Lyons
Stout, J. Phillip, Jersey City

HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets on fourth Tuesday of January, April, July, and October, April being the Annual Meeting.

ACTIVE MEMBERS

Baker, Philip W., High Bridge
Bambara, Aurelius J., Flemington
Beatty, Hannah J., Clinton Farms, Clinton
Boyer, Charles G., Annandale
Christensen, Alexander H., Lebanon
Clark, Frank G., White House Station
Coleman, Austin H., Clinton
Ctibor, Vladimir F., Califon
Dantzig, Henry, 41 Bridge st., Lambertville
Decker, Frederick H., Frenchtown
English, Samuel B., N. J. State Hosp., Glen Gardner
Felder, Samuel, 221 Main st., Flemington
Fluck, Paul H., 73 N. Union st., Lambertville
Fritz, John F., Jr., 95 Main st., Flemington
Fuhrmann, Barclay S., 10 Main st., Flemington
Fuhrmann, John B., 10 Main st., Flemington
Galeota, William, White House Station
Germain, Raymond J., High Bridge
Hamilton, Lloyd A., 46 York st., Lambertville
Harps, James A., 72 Center st., Clinton
Henry, George, 33 Mine st., Flemington
Jenkins, Arthur M., 701 Harrison st., Frenchtown
Knox, Howard A., New Hampton
Lane, Edgar W., 46 Main st., Bloomsbury
Lane, Edgar W., Jr., 46 Main st., Bloomsbury
Leaver, Morris H., Quakertown
McCorkle, William E., Ringoes
Merrill, Edwin D., R. D. No. 1, Titusville
Moran, John F., Jr., Army
Mullins, Roy L., 305 Harrison st., Frenchtown
Shangold, Jack E., 381 Park av., Perth Amboy
Simon, Fritz C., Hampton
Tompkins, Grenelle B., 52 Broad st., Flemington

HONORARY MEMBERS

Morrison, J. Bennett, Vista, California
Scammell, Frank G., Trenton
Sommer, George N. J., Trenton

MERCER COUNTY (11)

Society organized May 23, 1848. Meets on second Wednesday of each month except July, August, and September, at 9:00 p. m., in the State Society Headquarters, Trenton. Annual Meeting in December. Annual Banquet in November.

ACTIVE MEMBERS

Abey, William J. H., 65 S. Main st., Pennington
Abrams, Henry, 195 Nassau st., Princeton
Ackley, David B., 21 N. Clinton av., Trenton
Albert, Perry, 2780 S. Broad st., Trenton
Anthony, David W., 201 Witherspoon st., Princeton
Applegate, E.T.R., 621 N. Delmor av., Morrisville,Pa.
Applestein, Robert, 568 E. State st., Trenton
Aronis, Harry R., 935 W. State st., Trenton
Ashley, Harmon H., 20 Nassau st., Princeton
Austin, Henry J., 96 Bellevue av., Trenton
Barlow, John D., 232 Stockton st., Hightstown
Barrows, Arthur M., 440 Hamilton av., Trenton
Barry, R. Grant, 908 W. State st., Trenton
Bayne, Joseph K., Army
Beairsto, Everett B., 224 W. State st., Trenton
Belfer, Jacob J., 1235 Chambers st., Trenton
Belford, Ralph J., 90 Nassau st., Princeton
Bellis, Horace D., 437 E. State st., Trenton
Bergsma, Daniel, State Dep't. of Health, Trenton
Berman, Jacob J., 409 Market st., Trenton
Bernstein, Bertram, 35 Boudinot st., Trenton
Berry, Leonard M., 205 Nassau st., Princeton
Bird, Ivan F., N. J. State Hospital, Trenton
Blackwell, Enoch, 28 W. State st., Trenton
Blaugrund, Samuel, 833 W. State st., Trenton
Bonnet, W. Laurence, 2791Not'gham way,Mercerv'le
Borrella, Dominic D., 476 Hamilton av., Trenton
Burbidge, J. Raymond, 10 Bayard lane, Princeton
Burns, Joseph R., 254 S. Olden av., Trenton
Burroughs, Edmund W., 701 W. State st., Trenton
Byer, M. Yale, 442 Greenwood av., Trenton
Carabelli, A. Albert, 306 Hamilton av., Trenton
Carroll, C. Walter, 125 Centre st., Trenton
Carroll, William V., 211 Academy st., Trenton

Cella, Charles F., 359 Hamilton av., Trenton
Charleroy, Durant K., 935 Greenwood av.. Trenton
Chesner, William A., 1111 Hamilton av., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton
Clark, Alice L., 206 W. State st., Trenton
Clement, John B., 178 W. State st., Trenton
Clunan, Ambrose P., 851 Hamilton av., Trenton
Cohan, Charles C., 217 W. Hanover st., Trenton
Cohan, Joseph, 217 W. Hanover st., Trenton
Cohen, Herman, 1301 Hamilton av., Trenton
Cohen, William, 1007 Greenwood av., Trenton
Colavita, James J., 433 Princeton av., Trenton
Comfort, John B., 50 S. Clinton av., Trenton
Commini, Frank F., 439 Bellevue av., Trenton
Conte, Andrew N., 1018 S. Broad st., Trenton
Corio, George A., 307 S. Clinton av., Trenton
Corrigan, Patrick H., 1720 S. Broad st., Trenton
Cotton, Henry A., Jr., Dept. Inst. and Agenc's, Tr'nt'n
Cottone, R. John, 683 Princeton av., Trenton
Cowlbeck, H. Donald, 224 W. State st., Trenton
Cox, Harold C., 208 Stockton st., Hightstown
D'Arcy, Walter E., 545 E. State st., Trenton
Davenport, Irwin P., 545 W. State st., Trenton
Davis, Harold L., 178 W. State st., Trenton
Davis, John E., Jr., N. J. State Hospital, Trenton
Davison, Royden W., 205 W. State st., Trenton
Dean, Guy K., Jr., Princeton rd., Plainsboro
Deitz, Joseph R., 320 Centre st., Trenton
Denelsbeck, J. Otis, 878 E. State st., Trenton
Dimun, John T., 1000 S. Broad st., Trenton
Dodge, James T., 1819 S. Broad st., Trenton
Doranz, Harold K., 502 W. State st., Trenton
Drezner, Henry L., 507 S. Warren st., Trenton
Eames, William N., 1871 Pennington rd., Trenton
Edwards, Walter R., 22 Annabelle av., Trenton
Elias, Elmer J., 474 Greenwood av., Trenton
Engelhart, Ferdinand K., 28 Oak lane, Trenton
English, Harrison F., III, 160 W. State st., Trenton
Ernest, Richard B., 240 W. State st., Trenton
Fabian, Paul L., 520 Princeton av., Trenton
Farmer, Walter D., 28 S. Main st., Allentown
Fessler, A. James, 1544 S. Broad st., Trenton
Fine, Sydney G., 868 Stuyvesant av., Trenton
Finegan, Paul J., 200 W. State st., Trenton
Finkle, Lester J., 225 Perry st., Trenton
Fiorello, Joseph R., 689 Princeton av., Trenton
Fluck, David A., 626 W. State st., Trenton
Forer, Robert, 227 Centre st., Trenton
Franklin, Charles M., 56 Elm rd., Princeton
Franzoni, Andrew E., 938 Brunswick av., Trenton
Friedman, Max, 849 W. State st., Trenton
Friedman, Meyer H., 949 W. State st., Trenton
Friedmann, Leonard L., 484 Princeton av., Trenton
Fuchs, Jacob N., 1267 S. Broad st., Trenton
Garber, Robert S., N. J. State Hospital, Trenton
Garwood, Norman W., Main st., Crosswicks
Gindhart, Floyd D., 1233 Hamilton av., Trenton
Gindhart, John H., 1233 Hamilton av., Trenton
Goldberg, Benjamin M., 1156 E. State st., Trenton
Goldman, Leo L., 325 Market st., Trenton
Goyne, James B., 2785 Main st., Lawrenceville
Graham, Ernest E., 4273 S. Broad st., Yardville
Granger, James R., 235 Spring st., Trenton
Gribbin, James A., 836 W. State st., Trenton
Guglielmelli, Angelo D., 449 Hamilton av., Trenton
Hafetz, M. Morris, 114 Centre st., Trenton
Haggerty, D. Leo, 227 N. Warren st., Trenton
Hammell, Frank M., 137 S. Main st., Allentown
Haney, John J., 850 Hamilton av., Trenton
Harman, J. Reginald, 824 W. State st., Trenton
Harman, William J., 740 W. State st., Trenton
Hess, George A., Titusville
Hiden, Joseph C., 199 Nassau st., Princeton
Hirschfield, Bernard A., 514 Greenwood av., Trenton
Hofbauer, Ernest, 695 Parkway av., Trenton
Horhovitz, George I., 324 S. Broad st., Trenton
Hunter, Floyd D., 3620 Nottingh'm way, Hamilton Sq.
Hutchinson, A. Dunbar, 913 W. State st., Trenton
Hutchinson, Geo. F., 55 Mercer st., Hamilton Square
Ivins, William C., 455 W. State st., Trenton
James, J. Thomas, 57 Wiggins st., Princeton
Jaspan, Samuel C., 820 Division st., Trenton
Johnson, John F., 926 W. State st., Trenton
Kachdorian, Vartan, 935 Brunswick av., Trenton
Kinczel, John A., 971 S. Broad st., Trenton
Klempner, Paul, 637 Greenwood av., Trenton
Kline, Joseph J., 733 Hamilton av., Trenton
Knauer, Charles H., Jr., 198 W. State st., Trenton
Kohn, Joseph J., 201 Broad St. Bank Bldg., Trenton
Kohn, Ralph B., 201 Broad St. Bank Bldg., Trenton
Kondor, Joseph S., 978 S. Broad st., Trenton
Koplin, Nathaniel H., 142 W. State st., Trenton
Kustrup, John F., 1418 S. Broad st., Trenton
Lapin, Louis P., 15 Crosswicks st., Bordentown
Lapin, Mathew R., 628 W. State st., Trenton
Lavine, Barney D., 630 N. Clinton av., Trenton
Lavine, Sidney B., 144 W. State st., Trenton
Leshin, Harry, 564 S. Main st., Hightstown
Lettiere, Anthony J.. 425 E. State st., Trenton
Levy, Irvin, 222 W. State st., Trenton
Light, Arthur B., Lawr'ceville Sch'l, Lawrenceville
Little, William R., 493 W. State st., Trenton
Lloyd, Samuel J., 178 W. State st., Trenton
Lynch, Donald C., 885 Stuyvesant av., Trenton
MacDermid, Lynden E., 506 Farnsw'th av., Bordent'n
Magee, Harold S., N. J. State Hospital, Trenton
Magson, Albert E., 302 S. Main st., Hightstown
Majeski, Henry J., 930 Brunswick av., Trenton
McCarthy, William P., 1203 Parkside av., Trenton
McCullough, John H., 523 E. State st., Trenton
McGuigan, Francis A., 212 N. Warren st., Trenton
Means, Paul B., N. J. State Hospital, Trenton
Miller, Earle K., 2502 Nottingham way, Trenton
Miller, Gerald H., N. Main st., Cranbury
Miller, Raymond E., 192 W. State st., Trenton
Miller, Reginald C., 1420 Greenwood av., Trenton
Miller, Samuel R., 407 S. Main st., Pennington
Minschwaner, Geo. G., Jr., 832 Greenw'd av., Trenton
Mitchell, Charles H., 1100 W. State st., Trenton
Mitskas, Theo. V. J., 1329 Greenwood av., Trenton
Moore, J. Leonard, 38 Alexander st., Princeton
Moriconi, Albert F., 438 Hamilton av., Trenton
Mountford, William E., 215 N. Warren st., Trenton
Munro, Jeannette, 2 Queenston pl., Princeton
Murphy, James A., 312 Bellevue av., Trenton
Murto, Thomas V., 117 Buckingham av., Trenton
Nayfield, Ronald C., 974 S. Broad st., Trenton
Nonziato, Frank A., 50 Centre st., Trenton
Ogden, Andrew E., 1829 Greenwood av., Trenton
O'Neill, Joseph F., 41 E. Broad st., Hopewell
O'Rourke, James J., 871 Stuyvesant av., Trenton
Pantaleone, Joseph, 504 Hamilton av., Trenton
Parker, Horace N., 72 N. Clinton av., Trenton
Pepe, Salvatore A., 638 Perry st., Trenton
Pessel, Johannes F., 224 W. State st., Trenton
Peterson, Walter R., 312 W. State st., Trenton
Pierson, Carl L., 395 W. State st., Trenton
Pierson, Joseph R., 10 E. Broad st., Hopewell
Pinerman, Robert B., 308 W. State st., Trenton
Pittman, Allen R., N. J. State Hospital, Trenton
Potter, Ellen C., 301 W. State st., Trenton
Powis, Ethel M., 845 W. State st., Trenton
Poyas, Morton L., 306 W. State st., Trenton
Preece, John D., 178 W. State st., Trenton
Proctor, Francis E., 332 W. State st.. Trenton
Prunetti, Carmen, 311 Chestnut av., Trenton

Purcell, Ernest F., 800 Stuyvesant av., Trenton
Quackenbos, Harrie M., N. J. State Hosp., Trenton
Ragany, Joseph, 966 S. Broad st., Trenton
Rainey, Willard G., 34 Bayard lane, Princeton
Rampona, Joseph M., 272 Nassau st., Princeton
Reisinger, Paul B., 369 W. State st., Trenton
Rita, James J., 235 S. Clinton av., Trenton
Rogers, Laurence H., Donnelly Mem. Hosp., Trenton
Rose, William G., 232 Stockton st., Hightstown
Rowan, Henry M., 224 W. State st., Trenton
Sackin, Stanley, 834 W. State st., Trenton
Salvatore, Joseph T., 324 Hamilton av., Trenton
Salway, Benjamin, 321 S. Broad st., Trenton
Scammell, Frank G., 40 S. Clinton av., Trenton
Scasserra, Benedict B., 163 Nassau st., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Seely, Roy B., 104 N. Clinton av., Trenton
Seitzick-Robbins, H. E., 723 W. State st., Trenton
Sekerak, Albert J., 984 S. Broad st., Trenton
Shear, M. Murray, 1158 E. State st., Trenton
Sica, L. Samuel, 431 E. State st., Trenton
Siemion, Theophilis R., 1005 Brunsw'k av., Trenton
Sill, John B., Black Rock rd., Yardley, Pa.
Silver, E. Drew, 136 Stockton st., Hightstown
Slack, Clarence J., 230 W. State st., Trenton
Smith B. Earl, 1017 Greenwood av., Trenton
Smith, DeWitt H., 194 Nassau st., Princeton
Smith, Frank W., 1238 S. Clinton av., Trenton
Snegireff, Leonid S., 540 Parkway av., Trenton
Sommer, George N. J., 120 W. State st., Trenton
Sommer, George N. J., Jr., 120 W. State st., Trenton
Spradley, Jeems B., N. J. State Hospital, Trenton
Stabile, John A., Grand av., West Trenton
Steel, John M., N. J. State Hospital, Trenton
Stein, Louis A., 226 W. State st., Trenton
Storaci, Frank S., 715 Hamilton av., Trenton
Straus, Walter, 1239 Greenwood av., Trenton
Summers, Alfred D., 71 Palmer sq., Princeton
Sutnick, Theodore B., 25 Richey pl., Trenton
Swern, Nathan, 399 W. State st., Trenton
Swertfeger, Herbert W., 22 N. Greenw'd av., Hopew'l
Tenney, Luman H., 177 Prospect st., Princeton
Tomec, Otto C., 756 Parkway av., Trenton
Treiber, Benjamin A., 219 W. State st., Trenton
Tretter, Hans L., 501 W. State st., Trenton
Urbaniak, Henry S., 883 Brunswick av., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
Vanneman, Joseph S., 45 Princeton av., Princeton
Vento, Sebastian J., 452 Hamilton av., Trenton
Vol-Tretter, Marta, 501 W. State st., Trenton
Warter, Peter J., 717 W. State st., Trenton
Waters, Charles H., 928 W. State st., Trenton
Watov, Samuel E., 615 Beatty st., Trenton
Watson, Frederick S., 238 W. State st., Trenton
Watts, Wilbur, 436 E. State st., Trenton
Wayman, Bernard R., 1100 S. Broad st., Trenton
Wiesler, Howard M., Drawer N, Trenton
Wikoff, John L., 799 Pennington av., Trenton
Williams, Harry D., 829 W. State st., Trenton
Wilner, Arthur S., 205 Market st., Trenton
Wilner, Irving, 205 Market st., Trenton
Wittenborn, W. F. J., 1635 Brunswick av., Trenton
Wolff, Herbert M., 942 W. State st., Trenton
Yaeger, Leslie A., 470 Hamilton av., Trenton
York, Wilbur H., Box 110, Princeton
Zimskind, Joshua N., 210 W. State st., Trenton

ASSOCIATE MEMBERS

Apple, Stanley B., 108½ S. Overbrook av., Trenton
Berkowitz, Eva R., 110 Buckingham av., Trenton
Chandler, Swithin, Jr., 1100 S. Broad st., Trenton
Crane, Warren E., 11 Aberfeldy dr., Trenton
Eckstein, David, 407 Greenwood av., Trenton
Frisch, Felix, 726 W. State st., Trenton
Gardiner, Muriel M., Brookdale Farm, Pennington
Gian-Grasso, Joseph A., 971 S. Broad st., Trenton
Kaplan, Harry, 651 W. State st., Trenton
Katzenbach, C. Buckman, 497 W. State st., Trenton
Kren, Frank, 718 W. State st., Trenton
Larkin, Michael J., 705 Hamilton av., Trenton
Laufenberg, Joseph W., 1544 S. Broad st., Trenton
Ledden, Lewis J., 1104 Hamilton av., Trenton
Lynch, Cornelius G., 231 W. State st., Trenton
Mather, William B., 36 Edwards pl., Princeton
Moore, William J., 217 N. Warren st., Trenton
Parker, Paul, 72 N. Clinton av., Trenton
Pollard, William E., 194 Nassau st., Princeton
Rathauser, Frank, 399 W. State st., Trenton
Resnick, Nathan, 205 Market st., Trenton
Robinson, Aaron J., 635 S. Warren st., Trenton
Rosso, John D., 194 Nassau st., Princeton
Rothman, Sidney, 726 Chambers st., Trenton
Schnur, Bernard, 731 W. State st., Trenton
Smith, Percy L., W. Afton av., Yardley, Pa.
Sollami, William R., 2331 S. Broad st., Trenton
Sullivan, James M., III, 88 Spring st., Trenton
Taylor, Earl S., 2 Elm rd., Princeton
Taylor, John H., N. J. State Hospital, Trenton
Thurm, Arthur S., 225 W. State st., Trenton
Turner, Rodney C., 609 Greenwood av., Trenton
Vine, Blair, 662 Stuyvesant av., Trenton
Witman, H. John, Jr., 526 N. Clinton av., Trenton

HONORARY MEMBERS

Fell, Alton S., Trenton
MacFarland, Burr W., Trenton
Pierson, Theodore A., Hopewell
Taylor, Walter A., Trenton
Turner, Irvine F. P., Titusville
Wright, Howard E., Princeton

MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets on the third Wednesday of each month, October to June, inclusive. Annual Meeting in December.

ACTIVE MEMBERS

Adler, Howard E., 103 Livingston av., New Bruns'k
Adler, Lydia, 103 Livingston av., New Brunswick
Anderson, John F., 195 College av., New Brunswick
Avery, Philip S., Woodland ter., Bound Brook
Balogh, William A., 315 Front st., Dunellen
Barbano, Alfred J., 225 Hale st., New Brunswick
Bassett, Lavern C., 320 New Market rd., Dunellen
Belafsky, Henry A., 150 Green st., Woodbridge

Berkow, Samuel G., 138 Market st., Perth Amboy
Bowman, Ned O., 1001 Georges rd., New Brunswick
Breslow, Samuel, 157 Market st., Perth Amboy
Brody, Morton S., 67 Paterson st., New Brunswick
Calvin, Charles H., 80 Commerce st., Perth Amboy
Cannata, Benjamin, 113 Market st., Perth Amboy
Carr, Alexander M., S. Main st., Metuchen
Clarke, Francis M., 116 New st., New Brunswick
Cole, Nathaniel B., 104 Market st., Perth Amboy
Cooper, Irving J., 419 George st., New Brunswick
Cooperman, Eli L., 527 New Brunswick av., Fords
Copleman, Benjamin, 280 Hobart st., Perth Amboy
Copleman, Hyman B., 111 Liv'gst'n av.,NewBruns'k
Cottrell, Judson G., 159 Market st., Perth Amboy
Degenhardt, Ira H., 114 S. First st., Highland Park
Dieker, Howard E., 78 Main st., South River
Downing, Perley E., N. J. State Hospital, Trenton
Downs, Louis S., 143 Roosevelt av., Carteret
Dunham, Malcolm M., 88 Grove av., Woodbridge
Duschock, Edward F., 473 Amboy av., Perth Amboy
East, Isaac C., State Home for Boys, Jamesburg
Eulner, Elmer H., 216 Henry st., South Amboy
Fagan, James L., 51 Bayard st., New Brunswick
Fanelli, Antonio, 494 Compton av., Perth Amboy
Faulkingham, Ralph J., 61 Liv'gst'n av.,NewBr'ns'k
Feher, Ladislas A. M., 177 Somerset st., NewBr'ns'k
Fine, Hyman P., 151 Market st., Perth Amboy
Fine, Irvin J., Hobart Bldg., Perth Amboy
Fishkoff, Alexander H., 132 Market st.,Perth Amboy
Fithian, George W., 266 High st., Perth Amboy
Forney, Norman N., 94 N. Main st., Milltown
Forney, Norman N., Jr., Stelle av., Milltown
Forrest, Henry, Army
Friedenthal, Bernard, 88 Livingtson av.,NewBr'ns'k
Gadek, Stanley A., 95 Fayette st., Perth Amboy
Gadek, William V., 215 High st., Perth Amboy
Gerard, Arpad G., 502 Rahway av., Woodbridge
Gessner, Gerard R., 46 Union st., New Brunswick
Glasser, Benjamin F., 32 Lindon av., Highland Park
Gobel, Stanley J., Box 284, Bound Brook
Goldberg, Harry C., 7 Watchung av., Plainfield
Goldberg, Isidore, 303 N. Washington av., Dunellen
Goldman, Solomon, 161 Livingston av., New Br'ns'k
Gorog, Nicholas M., 159 Bayard st., New Brunswick
Greenwood, Wm. R., 106 College av., New Brunsw'k
Grossman, Walter, 77 Livingston av., N. Brunswick
Gurshman, Sol, 280 Amboy av., Metuchen
Gutowski, Joseph M., 433 Brace av., Perth Amboy
Haight, Harry W., 118 Raritan av., Highland Park
Hauber, Eugene A., 198 Washington rd., Sayreville
Haywood, Henry, 49 Paterson st., New Brunswick
Henry, Frank C., Jr., 214 Smith st., Perth Amboy
Hesseltine, Clair E., 305 Main st., South Amboy
Hilker, George F., 258 Maple st., Perth Amboy
Hinton, Samuel H., 123 Main st., Sayreville
Hofer, Clarence J. M., 463 Main st., Metuchen
Hoffman, Charles W., 226 David st., South Amboy
Hoffman, Florentine M., 91 Bayard st., New Bruns'k
Howell, E. Gaylord, 120 New st., New Brunswick
Howley, Barth, Jr., 67 Livingston av., New Brunsw'k
Hunt, Melvin M., 140 Jackson st., South River
Hutner, Cyril I., 134 Grove av., Woodbridge
Jacobson, Murray B., 137 Market st., Perth Amboy
Karshmer, Nathan, 92 Carroll pl., New Brunswick
Kelly, Leo J., Allentown
Kemeny, Imre, 48 Pulaski av., Carteret
Kleiber, Estelle E., 131 Livingston av.,NewBrunsw'k
Klein, Edward F., 136 Market st., Perth Amboy
Klein, William, 85 Bayard st., New Brunswick
Kler, Joseph H., 151 Livingston av., New Brunswick
Koelsch, Frederick J., 14 Kirkpatrick st.,NewBr'ns'k
Kohut, George J., 436 Amboy av., Perth Amboy
Krafchik, Louis L., 100 Bayard st., New Brunswick
Kramer, Bernard M., 254 State st., Perth Amboy
Kramer, Samuel E., 254 State st., Perth Amboy
Lang, Joseph, 111 Market st., Perth Amboy
Lavine, Samuel C., 502 Georges rd., New Brunswick
Lazow, S. Manlius, 199 Main st., Matawan
Leonard, George F., 63 N. 5th av., Highland Park
Levinson, Reuben, 123 Market st., Perth Amboy
Lewis, Collins E., 219 Seaman st., New Brunswick
Lind, Zoltan H., 215 Livingston av., New Brunswick
London, William, 255 State st., Perth Amboy
Long, Pauline A., 22 Livingston av., New Brunswick
Lucey, James J., 184 Market st., Perth Amboy
Mangogna, Philip, 334 Barclay st., Perth Amboy
Mann, Benjamin, 527 Amboy av., Perth Amboy
Mann, Jacob J., 255 State st., Perth Amboy
Margaretten, Edward I., 280 Hobart st., PerthAmb'y
Mark, Joseph S., 102 Green st., Woodbridge
Marvin, Dorothy H., 51 Livingston av., New Br'sw'k
McCormick, Wm. H., Jr., 266 Market st., P'thAmboy
McGovern, John F., Jr., 24 Liv'gst'n av.,NewBr'ns'k
McKiernan, Robert L., 97 Bayard st., New Brunsw'k
McKinstry, John W., Railroad av., Jamesburg
McLaughlin, Thomas F., 596 Main st., Metuchen
McLeod, Neill S., 729 Raritan av., Highland Park
Meinzer, Martin S., 147 Market st., Perth Amboy
Merrill, Charles F., 16 S. Third av., Highland Park
Messinger, Samuel, 31 Roosevelt av., Carteret
Miller, S. David, 90 Carroll pl., New Brunswick
Morris, Carlyle, Spring street, Metuchen
Nafey, Herbert W., 51 Livingston av., NewBrunsw'k
Naulty, Chas. W., Jr., 403 High st., Perth Amboy
Nieman, Solomon Z., 191 Livingston av., NewBr'ns'k
Normand, Alphonse F., 92 Haven av., N. Y. C.
O'Connell, James J., 116 Livingston av., NewBr'ns'k
Panigrosso, Louis R., 455 Lawrie st., Perth Amboy
Pansy, Abraham A., 12 Jackson st., South River
Pearson, J. Gerald, 75 Livingston av., New Brunsw'k
Pellicane, Anthony J., 183 Liv'gst'n av., New Br'ns'k
Platt, Thomas H., 215 Dunellen av., Dunellen
Putter, Eric, 180 N. Main st., Milltown
Racz, George, 22 Hardenbergh st., New Brunswick
Reason, John J., 612 Roosevelt av., Carteret
Reitman, Norman, 73 Livingston av., New Brunsw'k
Richlin, Padie, 316 George st., New Brunswick
Rineberg, Irving E., 137 Livingston av., NewBr'ns'k
Rona, Maurice, 10 Kirkpatrick st., New Brunswick
Rothfuss, C. Howard, 574 Rahway av., Woodbridge
Rothschild, Karl, 149 Livingston av., New Brunsw'k
Rowland, John H., 159 New st., New Brunswick
Rubin, William, 90 Bayard st., New Brunswick
Runyon, Laurence P., 80 Somerset st., New Bruns'k
Salaky, William L., 387 Neville st., Perth Amboy
Sandella, Jos. F., 138 Livingston av., New Brunsw'k
Saulsberry, Chas. E., 75 Livingston av., New Br'ns'k
Schirber, Rene G., 11 Kirkpatrick st., New Brunsw'k
Scott, Frederick W., 103 Bayard st., New Brunswick
Sender, Fannie, 193 Main st., South River
Shayevitz, Abraham S., 102 Main st., South River
Sherman, W. Edgar, 7 Livingston av.,NewBrunsw'k
Shull, John V., 184 Kearny av., Perth Amboy
Siegel, Isadore, 121 Market st., Perth Amboy
Silk, Charles I., 236 High st., Perth Amboy
Slobodien, Benjamin F., 233 High st., Perth Amboy
Smith, Ivan B., Georges rd., Dayton
Smith, John A., 106 Main st., South River
Smith, John V., 463 State st., Perth Amboy
Smith, Joseph A., N. J. State Hospital, Glen Gardner
Smith, Marshall, 62 Bayard st., New Brunswick
Smith Sydney F., 402 Raritan av., Highland Park
Sokoloff, Oscar J., 67 Paterson st., New Brunswick
Spencer, Ira T., 152 Main st., Woodbridge
Spritzer, Theodore D., 102 S. Wash'gt'n av.,Dunellen
Steffens, Charles T., 612 Park av., Plainfield
Stein, William, 177 Livingston av., New Brunswick
Sullivan, Chas. J., 57 Paterson st., New Brunswick

Szuch, Nicholas, 159 Main st., South River
Taber, Frederick S., 128 Graham st., New Brunswick
Tisch, Leon, 28 S. Third av., Highland Park
Toy, Calvert R., 22 Kirkpatrick st., New Brunswick
Tucker, Sidney, 182 Market st., Perth Amboy
Tyrrell, George W., 380 State st., Perth Amboy
Uhr, Jacques S., 127 Livingston av., New Brunsw'k
Ulan, Jerome, Main st., Spotswood
Urbanski, Matthew F., 148 Market st., Perth Amboy
Van Mater, John S., 216 S. Third av., Highland Park
Vargyas, Joseph C., 116 New st., New Brunswick
Walker, Robert B., 108 Church st., New Brunswick
Walters, George M., 158 Main st., Woodbridge
Wantoch, Joseph, 14 Carteret av., Carteret
Weber, John F., 264 Main st., South Amboy
Weiner, Henry T., 280 Hobart st., Perth Amboy
Wetterberg, Louis F., 74 Grove av., Woodbridge
White, Harry J., Roosevelt Hospital, Metuchen
Wiesenfeld, Benjamin, 138 Market st., Perth Amboy
Wilentz, William C., 188 Market st., Perth Amboy
Witmer, John D., 456 Middlesex av., Metuchen

ASSOCIATE MEMBERS

Becker, Meyer, 219 Amboy av., Metuchen
Berkow, Bori, 245 State st., Perth Amboy
Brezinski, Edward J., 473 Amboy av., Perth Amboy
Bristol, Frank E., II, Main st., Dayton
Brown, Milton B., 72 Roosevelt av., Carteret
Church, Charles F., Hillcrest River rd., N. Brunswick
Cowen, Mortimer I., 1330 Oak Tree rd., Iselin
Finnegan, William R., 265 Handy st., New Brunsw'k
Freeman, William S., 117 N. Third av., Highland Pk.
Gould, Louis F., 104 Washington st., Perth Amboy
Hamburg, Meyer M., 60 N. Sixth av., Highland Park
Idelcowitz, Marie, 123 Main st., South River
Jacobson, Benjamin D., 187 Liv'gst'n av., N.Br'nsw'k
Kant, Emanuel R., 240 High st., Perth Amboy
Koenig, Robert E., Sedgwick st., Jamesburg
Kunderman, Philip J., 215 Harper st., Highland Pk.
Leonard, Martha F., 55 N. Fifth av., Highland Park
London, Isabel M., 103 N. Fourth av., Highland Park
Marino, Benjamin, 14 Llewellyn pl., New Brunswick
Miller, Florian C., 136 Beaumont av.,Newt'nv'le,Mass.
Moolten, Sylvan E., 103 N. Fourth av., Highland Pk.
Morgenstern, Mates, 341 George st., New Brunswick
Myer, Clifton G., 115 Minna av., Avenel
Niemiera, Alexander K., 97 Kearny av., PerthAmboy
Pickar, Gabriel, 205 N. Second av., Highland Park
Romano, Frank, 207 Front st., Dunellen
Rosenberg, Norman, 10 Lincoln av., Highland Park
Scalera, John F., 28 S. Plainfield av., S. Plainfield
Siegel, Ralph E., 111 Market st., Perth Amboy
Silber, Irving M., 75 Livingston av., New Brunswick
Stollman, Bernard D., 21 John St., New Brunswick
Walker, Otto, 198 Pershing av., Carteret
Wiesenfeld, Paul, 104 Market st., Perth Amboy
Winfield, Irwin, 111 Livingston av., New Brunswick
Winn, James S., 131 Walnut st., Bound Brook
Winn, William M., 267 High st., Perth Amboy

HONORARY MEMBERS

Applegate, George T., New Brunswick
Burnett, Charles B., South River
Collins, James J., Woodbridge
Henry, Frank C., Sr., Perth Amboy
Lund, John L., Perth Amboy
Spencer, Ira T., Woodbridge
Tyrrell, Charles B., Perth Amboy
Voorhees, Howard C., New Brunswick

MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets on fourth Wednesday of each month from September to June, inclusive. Annual Meeting in April.

ACTIVE MEMBERS

Albright, Louis F., 118 Madison av., Spring Lake
Altschul, Frank J., 177 Garfield av., Long Branch
Andrews, Thomas H., 111 Main st., Matawan
Baer, Irving, 141 Broad st., Red Bank
Baeseman, R. Winfield, 112 Main st., Allenhurst
Baker, Elsworth F., N. J., State Hosp., Marlboro
Barnett, Lester A., 1201 Grand av., Asbury Park
Becker, Sidney D., 140 Maple pl., Keyport
Binder, Joseph, 101 Third av., Long Branch
Blaisdell, C. Byron, 489 Broadway, Long Branch
Booth, Herbert W., 401 Ludlow av., Spring Lake
Bornstein, Paul K., 320 Asbury av., Asbury Park
Bossone, Joseph E., 362 Bath av., Long Branch
Boyd, John B., 31 Oakland st., Red Bank
Bregman, Milton, 81 Union av., Manasquan
Brindle, Harry R., 501 Grand av., Asbury Park
Brown, Edith L., 340 Garfield av., Avon
Brown, Kenneth G., 501 Grand av., Asbury Park
Burkhead, Howard C., 541 Broadway, Long Branch
Captanian, Aram A., 159 Main st., Matawan
Carey, David S., 11 E. Main st., Freehold
Carter, Joseph F. S., 142 Atkins av., Asbury Park
Casagrande, Stephen R., 56 River rd., Rumson
Ciampa, Ralph P. E., 383 Bath av., Long Branch
Clark, John C., 501 Grand av., Asbury Park
Colby, Maxwell X., 133 Chelsea av., Long Branch
Costa, Philip L., 88 E. Front st., Red Bank
Daversa, Benjamin, 219 Madison av., Spring Lake
Delcau, Jules, 56 W. Main st., Freehold
D'Elia, William J., 2017 Fifth av., Spring Lake
Demaree, Richard H., 310 Norwood av, W.L'gBr'nch
Dengrove, Edward, 314 Grassmere av., Interlaken
dePons, Sarah C., 501 Grand av., Asbury Park
DeVita, Anthony J., Wilson av., Port Monmouth
Diamond, David I., Oceanport av., Oceanport
Dimitrow, Helen, 236 Broad st., Red Bank
Dorr, Henry B., 466 Broadway, Long Branch
Duvall, Albert I., N. J. State Hospital, Marlboro
Edelson, Samuel, 1611 Grand av., Asbury Park
Ellenson, Solomon S., 507 Fourth av., Asbury Park
Fazio, Vincent J., 104 Maple av., Red Bank
Feinberg, Harry D., 384 Second av., Long Branch
Feldman, Joel, Rumson rd., Rumson
Feman, J. George, 141 Main st., Keansburg
Fenton, Tennant E., 320 Ludlow av., Spring Lake
Ferguson, John, Monmouth Mem. Hosp., L. Branch

Fisher, James A., 501 Grand av., Asbury Park
Freedman, Harold H., 63 W. Main st., Freehold
George, Amerigo, 153 Third av., L. Branch
Gesswein, Carl A., 35 Church st., Matawan
Glazer, Edward, 550 Cookman av., Asbury Park
Goldberg, Jacob, 155 Franklin av., Long Branch
Gordon, J. Berkeley, N. J. State Hosp., Marlboro
Graber, Irving, 500 Tenth av., Belmar
Graves, Charles C., Jr., N. J. State Hosp., Marlboro
Halbstein, Bernard M., 138 Bath av., Long Branch
Hancock, Michael Q., Third av. & River rd., Belmar
Hardy, John W., 53 Main st., Farmingdale
Hausman, Samuel W., 50 W. Front st., Red Bank
Heatley, William, Navy
Herrman, William G., 501 Grand av., Asbury Park
Heymann, Ernest F., 345 Broad st., Red Bank
Hindle, F. Lawton, 145 Maple av., Red Bank
Hodas, Sidney M., 268 Broad st., Red Bank
Holman, Francis W., 123 Broad st., Keyport
Holters, Otto R., 1002 Emory st., Asbury Park
Jamison, William F., 501 Grand av., Asbury Park
Jones, Helen E., 617 Seventh av., Asbury Park
Jordan, Alex. D., 238 E. Main st., Manasquan
Jordan, Joseph C., Box A, Manasquan
Kazmann, Harold A., 710 Mattison av., Asbury Park
Knapp, Victor, 505 Second av., Asbury Park
Koch, William, 1000 Grand av., Asbury Park
Krohn, Marc, Campbell av., Belford
Leonard, Lothair L., 615 Asbury av., Asbury Park
Levin, Jack, 95 W. Main st., Freehold
Lewis, Jacob, 43 Court st., Freehold
Long, Elias E., 85 W. Front st., Red Bank
Lovett, Irving K., 110 E. Front st., Red Bank
Luca, Frank, 563 Westwood av., Long Branch
Luca, Mildred O., 563 Westwood av., Long Branch
Lussier, Georges H., Brisbane Tr'tm't Cen., Farm'gd'le
MacKenzie, Robert A., 501 Grand av., Asbury Park
Maher, John E., 90 Third av., Long Branch
Makin, John B., 501 Grand av., Asbury Park
Manahan, Daniel V., 55 E. Front st., Red Bank
Matthews, William, 139 Broad st., Red Bank
McCreight, David W., N. J. State Hosp., Marlboro
McCurdy, Robert G., 94 W. Highland av., Atl. Highl'ds
McDonnell, George J., 80 W. Main st., Freehold
McKelvie, Julius C., 55 Rockwell av., Long Branch
McTague, Robert S., 88 3rd av., Atlantic Highlands
Miele, Frank A., 314 Carr av., Keansburg
Mohair, John P., N. J. State Hosp., Marlboro
Mulligan, Edward W., 81 Shrewsbury av., Red Bank
Murphy, Charles M., 50 Edgemere dr., Matawan
Nathanson, Norman, 489 Broadway, Long Branch
Neiderhoffer, Sydney L., 469 Broadway, LongBranch
Nichols, Stanley H., 517 Broadway, Long Branch
Niemtzow, Frank, 55 E. Main st., Freehold
Opfermann, John L., 167 Bay av., Highlands
Osborn, A. Downey, 519 Sixth av., Belmar
Parry, Oliver K., 601 Bangs av., Asbury Park
Perrine, Cornelius C., 668 River rd., Fair Haven
Perrotta, Anthony J., 42 Harding rd., Red Bank
Pieper, Howard C., 120 Main st., Keyport
Pietri, Raoul, 501 Grand av., Asbury Park
Pignataro, Frank P., 342 Broad st., Red Bank
Pleasants, Edward N., N. J. State Hosp., Marlboro
Podell, A. Alfred, 51 E. Front st., Red Bank
Pons, Carlos A., 501 Grand av., Asbury Park
Pregnall, James P., 501 Grand av., Asbury Park
Quirk, Martin A., 75 W. Front st., Red Bank
Raffetto, Joseph F., 601 Bangs av., Asbury Park
Reynolds, Donald G., 64 W. Main st., Freehold
Reynolds, George G., 64 W. Main st., Freehold
Rifici, Anthony L., 1010 Grand av., Asbury Park
Robinson, Ernest A., 149 Atkins av., Asbury Park
Robinson, William A., 62 Main av., Ocean Grove
Rocco, Leo C., 75 Maple av., Red Bank
Rubin, Adrian D., 401 First av., Asbury Park
Rubin, Harold, 710 Mattison av., Asbury Park
Rullman, Walter A., 58 W. Front st., Red Bank
Sacco, Gregory E., 191 Broad st., Red Bank
Schlossbach, Theodore, 94 S. Main st., Ocean Grove
Schmidt, Albert F., 218 Boston blvd., Sea Girt
Sewell, Stephen, 320 Passaic av., Spring Lake
Shanik, William, 710 Mattison av., Asbury Park
Shapiro, Saul J., 50 E. Lincoln av., Atl. Highlands
Siegel, Victor, 43 E. Front st., Red Bank
Slocum, Harry B., 263 Bath av., Long Branch
Stevenson, George S., R. D. Box 556, Red Bank
Strahan, Frank G., 473 Broadway, Long Branch
Strauss, Arthur, 130 Pavilion av., Long Branch
Thomas, Harry G., 1113 Fifth av., Asbury Park
Trippe, Clarence M., 702 Asbury av., Asbury Park
Trippe, Morton F., 702 Asbury av., Asbury Park
Upham, Helen F., 305 Third av., Asbury Park
Von Oehsen, William H., 623 Fourth av., Bradley B.
Villapiano, Joseph G., 701 Sunset av., Asbury Park
Wainright, Melvin A. R., 286 Broad st., Red Bank
Wilbur, Franklin L., 515 Eighth av., Asbury Park
Wilkins, Stanley O., 47 E. Front st., Red Bank
Willey, Harry S., Jr., 112 Broad st., Red Bank
Wilson, Robert B., 91 Broad st., Red Bank
Woodruff, Ralph G., Main st., Englishtown
Worthington, Joseph A., 609 Fourth av., BradleyB'ch

ASSOCIATE MEMBERS

Adler, Samuel, 229 Broad st., Red Bank
Crilly, James A., 17 Pitney av., Spring Lake
Dedick, Andrew P., Jr., 118 Branch av., Red Bank
DeSimone, Louis E., 508 Fifth av., Asbury Park
Dreyfors, Madeline K., N. J. State Hospital, Marlboro
Goldstein, Benjamin, 710 Mattison av., Asbury Park
Guito, Frank, 626 Mattison av., Asbury Park
Haut, Edward M., 21 Main st., Farmingdale
Heisen, Aaron J., Imlaystown
Hummel, Frederick W., 606 F st., Belmar
Isen, Paul J., 600 Third av., Bradley Beach
Knowles, Frederick, 300 Brooklyn blvd., Sea Girt
Mazzei, Armand S., 710 Mattison av., Asbury Park
McGreevey, Harold, 314 Brighton av., Spring Lake
Payne, Douglas, 501 Grand av., Asbury Park
Pisani, Anthony A., Branch av., Little Silver
Raphael, Chester, N. J. State Hospital, Marlboro
Rush, Martin R., 326 Broad st., Red Bank
Schmaier, Sica L., 1107 Grand av., Asbury Park
Schneider, Leonard, 618 Brinley av., Bradley Beach
Steller, Frederick C., 314 St. Clair av., Spring Lake
Thompson, Victor, 80 W. Front st., Keyport
Verga, Armand, 20 Main st., Manasquan
Whelan, Vincent, 67 E. Front st., Red Bank
Winder, Miles S., Jr., 114 Allen av., Allenhurst

HONORARY MEMBERS

Bryan, Joseph A., Asbury Park
Jones, Granville L., Williamsburg, Virginia
Ransohoff, Nicholas S., Long Branch
Straughn, Clinton C., Red Bank

MORRIS COUNTY (14)

Society organized June 11, 1816. Meets on the third Thursday in October, December, March and June. Annual Meeting in June.

ACTIVE MEMBERS

Abraham, Albert, 15 Altamont ct., Morristown
Alcaro, Joseph A., 16 W. Blackwell st., Dover
Atkinson, John M., 93 Greenwood av., Madison
Baker, Augustus L., 389 W. Blackwell st., Dover
Beaver, Jennie D., 44 Elm st., Morristown
Benz, Francis J., 30 Lum av., Chatham
Bertha, Nicholas A., 301 S. Main st., Wharton
Bird, Frank L., Main st., Netcong
Blake, Dexter B., R. F. D. 1, Far Hills
Blanchard, Charles L., 28 E. Blackwell st., Dover
Bobadilla, Juan E. B., 2 Mercer st., Dover
Booth, William K., 304 William st., Boonton
Borkow, Philip, 45 E. Blackwell st., Dover
Bowers, F. Clyde, Mountain av., Mendham
Breuder, Andrew B., Whippany rd., Whippany
Byrne, J. Arthur, 16 Elm st., Morristown
Carleton, Charles K., 266 S. Main st., Wharton
Cohen, Oscar H., 115 Church st., Boonton
Collins, Laurence M., N.J. State Hosp.,Greyst'ne P'k
Comeau, George W., 415 Speedwell av.,Morris Plains
Cook, Dora G., 317 Cornelia st., Boonton
Corwin, Emanuel M., 5 Richards av., Dover
Costello, William F., 55 W. Blackwell st., Dover
Coultas, Aldo B., 1 Madison av., Madison
Crandell, C. Archie, N. J. State Hosp., Greystone Pk.
Cummins, Ella F., 39 Elm st., Morristown
Curry, Marcus A., N. J. State Hosp., Greystone Park
Dailey, Jeremiah, 57 Madison av., Madison
DeFelice, Mario T., 790 E. Clarke pl., Orange
DeGregorio, Peter J., 56 Prospect st., Madison
Deichman, Charles H., 39 Elm st., Morristown
Dirdack, Morris, 13 DeHart st., Morristown
Dochtermann, Warren P., R. D. 1, Stanhope
Donovan, Joseph, N. J. State Hosp., Greystone Park
Dredge, Thomas J., N. J. State Hosp., GreystonePk.
Earp, Ruth, 15 Olcott av., Bernardsville
Eckhardt, Ralph A., 50 Green Village rd., Madison
Emory, George B., Jr., 1 Franklin pl., Morristown
Esposito, Amedeo C., N. J. State Hosp.,GreystonePk.
Evans, Edgar J., Second av., Denville
Failmezger, Theodore R., 125 Green av., Madison
Falvello, Nicholas A., 28 Wetmore av., Morristown
Fenimore, Frank D., N. J. State Hosp., Greystone P.
Ferriss, Ruth B., 51 Maple av., Morristown
Finby, Nathaniel, 46 Main st., Netcong
Forbes, John S., Jr., W. Craig st., Basking Ridge
Frost, Inglis F., 181 South st., Morristown
Gambill, Perry J., N. J. State Hosp., Greystone Park
Gantt, Margaret H., 43 Hillcrest rd., Madison
Geary, Daniel J., 40 Maple av., Morristown
Gebirtig, Theodore, N. J. State Hosp., GreystonePk.
Gianni, Angelo R., 37 Main st., Netcong
Gilbertson, Robert L., 26 Maple av., Morristown
Giordano, Salvatore, 13 DeHart st., Morristown
Glazebrook, Francis H., "HoneysuckleW'ds,"Rumson
Gordon, Charles D., Mt. Arlington
Graddick, Lester W., 22 Sussex av., Morristown
Grant, Raymond J., 69 S. Morris st., Dover
Gregory, Marie F., 50 Green Village rd., Madison
Griscom, I. Norwood, 204 Church st., Boonton
Hampton, George R., N.J. State Hosp.,GreystonePk.
Harrington, J. Henry, 126 E. Main st., Rockaway
Hatch, Harold S., Shonghum Mt. Sana., Morristown
Haven, Samuel C., 14 Elm st., Morristown
Hiler, Stuart A., 62 Rockaway av., Rockaway
Hogan, Marshall D., 311 W. Main st., Boonton
Hopping, John S., River rd., Hanover
Hornick, Emil E., 307 Spruce st., Boonton
Hubert, Antonio O., 131 E. Main st., Rockaway
Ivey, Evelyn P., Lake Valley rd., Morristown
Johnston, Julian F., 21 Van Doren av., Chatham
Kent, Donald F., 396 Main st., Chatham
Kessler, Edward I., N.J. State Hosp., Greystone Pk.
King, Alden P., 400 W. Blackwell st., Dover
Klein, Milton, 45 E. Blackwell st., Dover
Klein, Solomon, 11 High st., Morristown
Kossmann, Walter J., Long Valley
Krauss, Fletcher I., 407 Main st., Chatham
Kuite, George B., 435 Speedwell av., Morris Plains
Larson, Henry M., 35 Franklin st., Morristown
Lathrope, George H., 965 Broad st., Newark
Laudig, Guy H., 361 Speedwell av., Morris Plains
Levendusky, Daniel E., 20 W. Main st., Rockaway
Luddecke, Hugh F., Morristown Mem. Hosp.,M'r'st'n
Luippold, Eugene J., Jr., 68 Lookout rd., Boonton
Mathews, Raymond H., 186 South st., Morristown
McCluskey, Harry B., Morristown rd., Whippany
McMahon, Bernard C., 15 James st., Morristown
McMurtrie, William A., 20 Franklin st., Morristown
Melvin, Daniel G., N. J. State Hosp., Greystone Park
Menden, Julian, 45 E. Blackwell st., Dover
Mills, Clifford, 36 Maple av., Morristown
Mintz, Alvin R., 32 Maple av., Morristown
Musetto, Carmelo A., 135 Cornelia st., Boonton
Navazio, Attilio, 29 DeHart st., Morristown
Nicoll, George L., Succasunna
Oestreicher, Harry, Picatinny Arsenal, Dover
Palazzo, William L., 2210 Starling av., Bronx, N. Y.
Parry, Allen A., 46 Green Village rd., Madison
Parry, Antoinette R., 93 Greenwood av., Madison
Pinckney, Frank H., 186 South st., Morristown
Plume, Clarence A., Main st., Succasunna
Pottinger, William E., 6 Altamont court, Morristown
Prager, Bert A., 511 Main st., Chatham
Reed, Robert R., 65 Washington st., Morristown
Renna, Francis, 20 Morris av., Morristown
Rice, Franklin W., 184 South st., Morristown
Riley, Philetus H., 181 South st., Morristown
Rosen, Herbert J., 42 Hudson st., Dover
Rosenberg, Alvin A., 22 High st., Morristown
Rubens, Otto, Box 482, R. D. 2, Dover
Rubin, Henry S., 11 High st., Morristown
Ryman, Merlin T., 5 Dunbar st., Chatham
Saltus, Lloyd S., 16 Elm st., Morristown
Seward, Frederic H., 40 Green Village rd., Madison
Shanik, Morton J., 55 W. Blackwell st., Dover
Sherman, Byron G., 52 Maple av., Morristown
Spencer, Alvan, 395 W. Blackwell st., Dover
Stage, Earl DeW., 37½ James st., Morristown
Steuart, David F. R., 9 Armstrong rd., Morristown
Talmage, William G., Main st., Succasunna
Teller, Daniel W., Jr., 28 DeHart st., Morristown
Terreri, D. Joseph, 30 High st., Morristown
Thomas, Thomas S., Jr., 18 Elm st., Morristown
Truax, Alfred J., Chester
Van Wiemokly, Seymour S.,201 Speedw'l av.,Morrist'n
von Deilen, Henry O., 28 DeHart st., Morristown
Voorhies, Wm. S., Jr., N.J. State Hosp.,GreystonePk.
Voss, J. Landon, 21 Mt. Airy rd., Bernardsville
Ward, Albert J., 39 Elm st., Morristown
Warne, Merna M., N.J. State Hosp., Greystone Park
Weiss, Herman, Aurora Institute, Morristown
Williams, David P., 116 Lake dr., Mountain Lakes
Williams, Louis E., 80 Green av., Madison
Woodman, Charles B., 25 Ogden pl., Morristown
Young, George J., 60 Maple av., Morristown
Zimmerman, Robert F., 28 Wash'gton av.,Morrist'n
Zuloff, D. Blair, 3 Community pl., Morristown

HONORARY MEMBERS

Baker, Augustus L., Dover
Costello, William F., Dover
Coultas, Aldo B., Madison
Curry, Marcus A., Greystone Park
Glazebrook, Francis H., Rumson
Gordon, Charles D., Mt. Arlington
Hampton, George R., Greystone Park
Haven, Samuel C., Morristown
Lathrope, George H., Newark
Mills, Clifford, Morristown
Plume, Clarence A., Succasunna
Prager, Bert A., Chatham
Seward, Frederic H., Madison

OCEAN COUNTY (15)

Society organized October 28, 1903. Meets on second Wednesday of each month except July and August. Annual Meeting in May.

ACTIVE MEMBERS

Alpert, Sidney, 235 Fourth st., Lakewood
Appleton, Ralph, Lincoln av., Point Pleasant
Buermann, Robert, 206 Madison av., Lakewood
Bunnell, Frederick N., 22 S. Main st., Barnegat
Carmona, L. Roberto, 141 Wood st., Tuckerton
Dodd, William E., Ocean st. & Bay av., Beach Haven
Gartlan Bernard W., Main st., Toms River
Gebele, William X., Jr., 310 Main st., Lakewood
Goldstein, Abraham, 404 Madison av., Lakewood
Green, Thomas J., New Egypt
Hayden, Walter G., 504 Main st., Toms River
Henriksen, J. Bruce, 422 River av., Point Pleasant
Herbener, Eugene G., 423 Third st., Lakewood
Ivory, Harry S., Richmond av., Point Pleasant
Lehmacher, Frank, 16 Central av., Lakewood
Menge, Carl H., 236 Washington st., Toms River
Mitchell, Willis B., 109 W.Washington st.,Toms Riv'r
Nyvall, Pierre J., Barnegat
Obert, J. Edwin, Main st., New Egypt
Pecora, Carmine L., 212 Washington st., Toms River
Rinzler, Harvey, 614 Main st., Toms River
Sawyer, Blackwell, 109 Washington st., Toms River
Schneider, Clinton R., 125 N. Green st., Tuckerton
Sickel, Emanuel M., 318 Forest av., Lakewood
Szold, Norman F., 701 Princeton av., Lakewood
Taylor, Raymond A., 58 Madison av., Lakewood
Towbin, Adolph, 326 Third st., Lakewood
Wentz, Irl Z., 224 Webster av., Seaside Heights
Witte, C. Norman, 422 River av., Point Pleasant
Yurevich, Antony, County Line rd., Lakewood

PASSAIC COUNTY (16)

Society organized January 14, 1844; Society chartered November 14, 1843. Meets on third Tuesday of each month except June, July and August. Annual Meeting in May.

ACTIVE MEMBERS

Achtentuch, Herman, 113 Sherman st., Passaic
Ackerhalt, Martin J., 408 Clifton av., Clifton
Adler, Fritz F., 777 Market st., Paterson
Allen, Arthur A., 365 Park av., Paterson
Allen, Edwin J., 269 Carrol st., Paterson
Allen, James M., 585 Main st., Passaic
Alpren, Bernard F., 17 Church st., Paterson
Andrews, Albert G. K., 238 Sherman st., Passaic
Angell, Emmett D., 1 Catherine st., Bloomingdale
Apter, Abraham H., 45 Church st., Paterson
Ash, Frank W., 180 Carroll st., Paterson
Atwood, Edward A., 360 Park av., Paterson
Averbach, Jacob, 435 Clifton av., Clifton
Balles, Edward S., 392 Park av., Paterson
Barlow, Frank A., Navy
Barolsky, Benjamin, 811 E. 22nd st., Paterson
Barone, Leo J., 392 Van Houten st., Paterson
Barr, Joseph, 975 Madison av., Paterson
Baxt, Sidney J., 544 21st av., Paterson
Becker, Frank F., 337 E. Ridgewood av., Ridgewood
Becker, George L., 646 E. 28th st., Paterson
Becker, Leo V., 69 Ward st., Paterson
Bender, Theodore, 666 Broadway, Paterson
Benjamin, Joseph F., 203 Godwin av., Ridgewood
Bergin, Joseph V., 315 Broadway, Paterson
Berk, M. David, 33 Bartholf av., Pompton Lakes
Berkhout, Peter G., 106 Haledon av., Prospect Park
Bernson, Samuel T., 33 Bartholf av., Pompton Lakes
Biczak, Arkad K., 311 Lexington av., Clifton
Blake, Albert J., 640 Broadway, Paterson
Bohl, Louis J., 320 Broadway, Paterson
Bongiorno, Henry D., 516 River st., Paterson
Bornstein, David, 566 Broadway, Paterson
Botbyl, Burt W., 927 Madison av., Paterson
Boylan, Lawrence B., 630 Main st., Paterson
Brancato, Peter, 93 E. 38th st., Paterson
Brancone, Alphonse M., 417 21st av., Paterson
Brogan, Francis B., 234 E.,32nd st., Paterson
Bromberg, Charles B., 107 Lexington av., Passaic
Bronner, Alfred, 95 Jackson st., Passaic
Brooks, Sidney S., 380 12th av., Paterson
Budd, J. Reuben, 379 Clifton av., Clifton
Bullen, Victor E., 148 Hamilton av., Paterson
Butterfield, Arey A., 655 Main av., Passaic
Calligaro, Egildo A., 288 Parker av., Clifton
Capell, Harry H., 302 Broadway, Paterson
Capio, Mario D., 293 Broadway, Paterson
Carlisle, John H., 129 Prospect st., Passaic
Carlough, David J., 426 Ellison st., Paterson
Catanzaro, Francesco, 151 Jefferson st., Passaic
Chapnick, Maurice M., 715 Broadway, Paterson
Charney, William, 546 Broadway, Paterson
Cherry, Homer H., Valley View Sana., Paterson
Chester, Saul W., 634 Broadway, Paterson
Chilton, Forrest S., Pompton Plains
Chrisman, Irving, 423 Broadway, Paterson

Chudzik, Edward W., 749 Midland av., Garfield
Churg, Jacob, Barnert Memorial Hosp., Paterson
Ciccone, Anthony C., 389 Grand st., Paterson
Clark, Orlo H., 149 Prospect st., Passaic
Close, Byron H., Hamburg Turnpike, Bloomingdale
Cogan, Henry, 117 Beverly ct., Daytona Beach, Fla.
Cohen, Julian, 592 E. 29th st., Paterson
Cohen, Louis, 257 Paulison av., Passaic
Cohen, M. Marvin, 582 E. 25th st., Paterson
Cohn, Isidor, 231 Lexington av., Passaic
Cole, L. Frank, 388 Terhune av., Passaic
Connolly, Joseph P., Hamilton & Ward sts., Paters'n
Conserva, Peter V., 196 Randolph av., Clifton
Cortese, Alvin E., 26 Ward st., Paterson
Cotton, Norman T., 219 Graham av., Paterson
Cremens, John F., 144 Carroll st., Paterson
Crescente, Fred J., 827 Madison av., Paterson
Crounse, David R., 84 Broadway, Passaic
Curtis, A. Maurice, 445 Van Houten st., Paterson
Davis, A. Hobson, Paterson General Hosp., Paterson
Dawson, Harry, 618 E. 24th st., Paterson
DeBell, Peter J., 65 Summer st., Passaic
DeGrace, Francis H., 311 Paulison av., Passaic
Deich, Samuel R., 162 Lexington av., Passaic
Delario, Anthony J., 316 Broadway, Paterson
Della Penna, Samuel J., 320 Ramapo av., Pompton L.
Del Mauro, Alphonse, 460 Park av., Paterson
DeMattia, Michael, 71 Ward st., Paterson
Denison, Ward C., 264 Lotte rd., Ridgewood
DeRosa, Armand, 262 Totowa rd., Paterson
Desmet, Victor F., 324 Broadway, Paterson
De Yoe, Leon E., 602 Broadway Paterson
Dingman, Norman M., 330 Broadway, Paterson
Doktor, David, 415 Park av., Paterson
Donnelly, Joseph E., 445 Market st., Paterson
Dow, Robert F., Army
Drake, Daniel E., Union Valley rd., Newfoundland
Dren, George W., 191 Lexington av., Passaic
Duncan, Owsley B., 414 Ellison st., Paterson
Dunning, Walter L., 533 River st., Paterson
Dwyer, Henry E., 261 Madison st., Passaic
Dwyer, William A., 99 Park av., Paterson
Edlkraut, Edward C., 320 Lexington av., Clifton
Ehrenfeld, Edward, 185 Lexington av., Passaic
Ehrenfeld, Irving, 185 Lexington av., Passaic
Eisemann, Jerome S., 38 Main st., Butler
Ekings, Frank P., 221 Broadway, Paterson
Esposito, Anthony L., 246 Lexington av., Passaic
Farkas, Gustav, 255 Harrison st., Passaic
Feigenoff, Israel, 271 Park av., Paterson
Feliciano, Vincent, 286 Lafayette av., Hawthorne
Fenster, Morton N., 202 Lexington av., Passaic
Fenwick, John R., 196 Lakeview av., Clifton
Ferrary, Paul B., 232 Totowa rd., Totowa
Fielding, William M., 15 Waldwick av., Waldwick
Fiering, Abraham M., Pompt'n Tnpk., Mount'n View
Fishbein, Elliot, Valley View Sana., Paterson
Fisher, Samuel, 808 Madison av., Paterson
Flitcroft, William, Wisconsin
Foote, Sherman K., Clinton av., Wyckoff
Fortay, Steven O., 474 Park av., Paterson
Fortuin, Floyd, 6 Church st., Paterson
Fraulo, Louis, 347 Crooks av., Clifton
Freedman, Jacob S., 178 Hamilton av., Passaic
Friedman, Edna C., 584 Broadway, Paterson
Gallardo, Agustin, 61 Lakeside av., Pompton Lakes
Gallo, James S., 160 Cabrini blvd., N. Y. C.
Garnett, Robert, 204 Madison st., Passaic
Geiger, Harold C., Main st., West Milford
Gellman, William B., 163 Valley Blvd., Wood-Ridge
Gelman, Sidney, 600 E. 27th st., Paterson
Giambra, Sante M., 440 Park av., Paterson
Giglio, Louis A., 182 Park av., Paterson
Ginsburg, Samuel, 227 Paulison av., Passaic
Glasgow, Thomas M., 120 Passaic av., Passaic
Gochman, Harry M., 166 Hamilton av., Paterson
Goldenberg, Raphael R., 588 E. 27th st., Paterson
Golding, Harry N., 180 Carroll st., Paterson
Goldman, Sol. B., Navy
Goldstein, Edward W., 561 E. 28th st., Paterson
Golish, Harry L., 425 15th av., Paterson
Gordon, Abel, 616 Main av., Passaic
Gordon, Samuel, 540 Park av., Paterson
Gordon, William, 648 Ringwood av., Wanaque
Gormley, Cyrus M., 15 Kiel av., Butler
Gould, John H., 92 Monte Vista av., Ridgewood
Graeter, F. Albert, 141 Broadway, Passaic
Graham, Archibald F., 42 Park av., Paterson
Graham, Theodore K., 279 Park av., Paterson
Greengrass, Jacob J., 146 Broadway, Paterson
Greenwell, Albert W., 6 S. Brookwood dr., Montclair
Grossbard, Paul, 211 Lexington av., Passaic
Guarraia, Joseph, 285 Van Winkle av., Hawthorne
Gurnee, Quinby D., 168 Diamond Br. av., Hawthorne
Hall, Wayne W., 515 Broadway, Paterson
Halnan, John J., Jr., 631 Madison av., Paterson
Hambright, Arthur M., Wyckoff av., Ramsey
Harreys, Charles W., 153 Prospect st., Ridgewood
Hatem, Elias J., 1046 Main st., Paterson
Hayman, Irving R., 681 Broadway, Paterson
Hillmann, Frederick C., 64 Hamilton st., Paterson
Hirsch, Samuel, 258 Lafayette av., Passaic
Hollingsworth, H. Hale, 86 First st., Clifton
Holmes, Thomas J. E., 151 Fair st., Paterson
Holster, Stephen G., 951 Madison av., Paterson
Holt, Herman H., 576 Broadway, Paterson
Hughes, J. Vernon, P. O. Box 454, Passaic
Ianacone, John A., 310 Fifth av., Paterson
Iraggi, James V., 53 Passaic av., Passaic
Izenberg, David, 555 E. 29th st., Paterson
Jaffe, Hyman, 149 Broadway, Passaic
Jahn, Albert G., 657 Main av., Passaic
Jani, Frank F., 297 Lexington av., Passaic
Jehl, Joseph R., 59 Harding av., Clifton
Joelson, Dora, 485 Park av., Paterson
Joelson, Morris S., 577 Broadway, Paterson
Joffe, Philip M., 556 E. 28th st., Paterson
Joffe, Sidney H., 556 E. 28th st., Paterson
Johnsen, Sigurd W., 149 Prospect st., Passaic
Joseph, Morris, 271 Lexington av., Passaic
Kaletkowski, Marion F., 10 Maple pl., Clifton
Katz, Harry, 494 Park av., Paterson
Keating, Charles A., 177 Ellison st., Paterson
Keating, Joseph M., 657 Main av., Passaic
Keller, Michael L., 673 E. 27th st., Paterson
Kelley, Ray H., 72 Wyckoff av., Midland Park
Kennedy, A. Andrew, 121 Hadley av., Clifton
Kennedy, Eugene T., 413 Wanaque av., PomptonLks.
Keppler, Charles, Jr., 723 Allwood rd., Clifton
Kim, Gay B., 703 Main st., Paterson
Kinney, Burton O., 41 Lincoln av., Little Falls
Kleiner, Samuel, 162 Hamilton av., Paterson
Kleinmann, Eberhart H., 560 Broadway, Paterson
Klughaupt, Dorothy K., 257 Boulevard, Passaic
Koenig, Bertram, 311 Broadway, Paterson
Koerber, George, 136 Prospect st., Passaic
Korman, Arnold, 726 Broadway, Paterson
Kovaleski, Walter A., 77 Market st., Passaic
Kovin, Abraham, 123 Lexington av., Passaic
Krieger, George, Army
Krugman, Benjamin M., 438 Park av., Paterson
Laauwe, Harold W., 360 Park av., Paterson
Landaw, Louis, 631 E. 26th st., Paterson
Lang, Richard E., 463 Passaic av., Passaic
Lawless, Edward T., 47 Hawthorne av., Bloomfield
Lawrence, Arthur C., Main st., Lincoln Park
Lawrence, Elias D., P. O. Box 1751, Paterson
Leach, John E., 17 Bancroft pl., Fair Lawn

Lee, Frederick P., 606 E. 27th st., Paterson
Lemay, Albert T., 532 14th av., Paterson
Levine, David B., 647 Broadway, Paterson
LeVine, Israel, 215 Broadway, Paterson
Levine, Sidney C., 459 Park av., Paterson
Levinsohn, Sandor A., 656 East 29th st., Paterson
Levy, David, 268 Park av., Paterson
Levy, Herman, 219 Lexington av., Passaic
Liana, Stephen M., 456 Park av., Paterson
Lima, John G., 292 Broadway, Paterson
Linares, A. Carfi, 208 Market st., Paterson
Lipton, Louis, 67 Passaic av., Passaic
Lobsenz, Nathan P., 294 Broadway, Paterson
Lomauro, James R., 184 Lexington av., Passaic
London, Jules R., 340 Paulison av., Passaic
London, Leslie, 119 Lexington av., Passaic
Low, Donald B., 529 Broadway, Paterson
Lucent, S. Bell, 2 First av., Little Falls
Luksteid, Casimir J., 326 Park av., Paterson
MacGahan, Wm. H., 516 Wanaque av., Pompt'nLks.
MacGregor, Allan W., 379 Ellison st., Paterson
MacGuffie, Robert N., 657 Main av., Passaic
Mackler, Meyer E., 627 E. 24th st., Paterson
Maclay, Joseph A., 239 Broadway, Paterson
Maffongelli, Joseph A., 494 River st., Paterson
Magnes, Max, 660 E. 23rd st., Paterson
Manly, Thomas E., 390 Park av., Paterson
Manzione, Frank A., 500 Union av., Paterson
Marini, Dominick, 40 Henry st., Passaic
Markel, Albert G., 450 Park av., Paterson
Markowitz, Louis, 380 Park av., Paterson
Marrocco, William A., 445 Park av., Paterson
Martin, Theodore, 577 Lincoln av., Glen Rock
Masucci, Alberico, 128 Carroll st., Paterson
Matthews, Leonard M., 655 Main av., Passaic
Mazzarella, Carlo, 237 Broadway, Paterson
McBride, Andrew F., Jr., 655 Broadway, Paterson
McCarthy, George L., 506 Union av., Paterson
McCue, John B., 118 Lenox av., Pompton Lakes
McDonald, Richard J., 80 Park av., Paterson
McPherson, Malcolm E., 141Diam'd Br.av.,H'wth'rne
Meier, William U., 1062 Ringwood av., Haskell
Meloney, Lester F., 156 Second st., Clifton
Meneve, Alfred D., 373 Broadway, Paterson
Meyers, Francis R., 680 Park av., Paterson
Michelson, Henry, 675 E. 24th st., Paterson
Missonellie, William, 404 Lafayette av., Hawthorne
Mitchell, Charles R., 311 Broadway, Paterson
Monaloy, Morris A., 26 Barry pl., Passaic
Morici, Theodore, 80 Howe av., Passaic
Morrill, James P., Jr., 310 Broadway, Paterson
Moscoe, Harry A., 320 Broadway, Paterson
Mott, Joseph E., 426 Park av., Paterson
Murn, Charles J., 48 Smith st., Paterson
Neer, William, 308 Woodside av., Ridgewood
Nemirow, Martin, 234 Lexington av., Passaic
Nesbitt, Elizabeth, N. Jersey Tr'n'g Sch'l,LittleFalls
Norris, Alfred W., 123 Prospect st., Ridgewood
Norval, Wm. A., Box 2904, St. Petersburg, Fla.
Notkin, Meyer, 559 Broadway, Paterson
Nussbaum, Nathan, 237 Lakeview av., Clifton
Nye, Howard H., 174 Carroll st., Paterson
O'Brian, Dennis M., 154 Lexington av., Passaic
O'Brian, Jeremiah H., 661 Main av., Passaic
Ogden, Michael A., 20 Grove st., Passaic
Okin, Irving, 165 Passaic av., Passaic
Opper, Philip, 606 E. 26th st., Paterson
Oram, Joseph H., 495 Broadway, Paterson
Palma, Nicholas, 116 17th av., Paterson
Palmer, Francis R., 220 Lexington av., Passaic
Paris, William, 518 E. 25th st., Paterson
Pasternack, Elroy, 255 Harrison st., Passaic
Patella, Fulvio, 324 Broadway, Paterson
Pernettl, Anthony M., 245 The By Way, Ridgewood
Phelps, James E., 203 Park av., Paterson
Piasecki, Chester A., 585 E. 29th st., Paterson
Piller, Jacob, 213 Broadway, Paterson
Pink, Solomon H., 21 High st., Butler
Plinke, Fritz W., 265 Gregory av., Passaic
Polizzotti, Joseph L., 193 Park av., Paterson
Pollock, Theodore, 64 Grove st., Passaic
Polowe, David, 555 E. 27th st., Paterson
Prince, Robert A., 567 Broadway, Paterson
Provisor, Benjamin, 271 Lexington av., Passaic
Raab, Michael, 250 Lexington av., Passaic
Radest, Louis J., 347 Broadway, Paterson
Randazzo, Anton P., 82 Prospect st., Passaic
Rauschenbach, Paul E., Jr., 612 E. 29th st., Paterson
Reading, H. Eugene, 535 E. 29th st., Paterson
Reeves, Ernest, 195 Lexington av., Passaic
Reilly, Thomas F., 127 Union av., Clifton
Reiner, David N., Army
Reinhorn, Abraham J., 297 Broadway, Paterson
Reinkraut, Arthur D., 175 Broadway, Passaic
Riccobono, Cosmo S., 334 Park av., Paterson
Rinzler, Harry G., 127 Van Houten av., Passaic
Ritter, John J., Box 86, Plainfield, Mass.
Robertson, Eugene V., 326 Lafayette av., Hawthorne
Roemer, Jacob, 591 E. 27th st., Paterson
Rogers, James A., 274 Carroll st., Paterson
Romano, Michael J., 2 Arlington pl., Radburn
Ross, Peter W., 655 Main av., Passaic
Roy, Joseph N., 95 17th av., Paterson
RuBacky, Joseph F., A., 61 Passaic av., Passaic
Ruocco, William B., 416 River st., Paterson
Russell, Charles B., 119 Hamilton av., Paterson
Sabarese, Theodore C., 122 Marsellus pl., Garfield
Saco, Louis S., 922 Main st., Paterson
Saffron, Morris H., 292 Paulison av., Passaic
Sala, Aldo W., 172 Randolph av., Clifton
Salter, Kent, Valley View Sana., Paterson
Salzman, Nathan, 714 Broadway, Paterson
Sanfacon, Thomas A., 340 Park av., Paterson
Santangelo, Emil L., 313 18th av., Paterson
Sarokhan, Joseph, 771 Madison av., Paterson
Schafer, Marguerite A., 298 D'mondBr.av.,H'wth'rne
Schefrin, Alexander E., 235 Lexington av., Passaic
Schleifer, Arnold, 10-04 River rd., Fairlawn
Schlossberg, Ezra, 175 Broadway, Passaic
Schubert, Roy R., 466 Park av., Paterson
Schultz, Augustin M., 379 Union av., Paterson
Schwartz, Jacob R., 7-06 Fairlawn av., Fair Lawn
Schwartz, Leo, 301 Harrison st., Passaic
Schwartz, William, 224 Lexington av., Passaic
Schwartzberg, Frederick I., 522 Broadway, Paterson
Schwarz, Julianna L., 57 Passaic av., Passaic
Scielzo, Nicholas F., 369 Park av., Paterson
Scovern, Louis, 112 Westervelt pl., Passaic
Scribner, Chas. H., R.F.D.1, Hamb'g Tnpk.,Pat'ers'n
Shapiro, David, 546 Broadway, Paterson
Shapiro, Louis G., 375 Broadway, Paterson
Shechtman, Abraham, 37 Grove st., Passaic
Sheft, Matthew J., 112 Lexington av., Passaic
Shinefeld, Maurice A., 669 Broadway, Paterson
Shipman, Meyer P., 575 Broadway, Paterson
Shulman, Abraham, 528 E. 29th st., Paterson
Siciliano, Thomas, 6 Clinton av., Clifton
Silverman, Irving A., 260 Dayton av., Clifton
Simkin, Abraham, 232 Broadway, Passaic
Simon, Philip H., 174 Columbia av., Passaic
Slaff, Florence, 16 Grove st., Passaic
Sloan, Samuel L., 182 Belmont av., Paterson
Small, Louis, 101 Prospect st., Passaic
Smith, Elroy W., 309 E. DeLido dr., Miami B'ch,Fla.
Smith, Leon A., 655 Main av., Passaic
Sobel, I. Jerome, 136 Broadway, Passaic
Stark, Jacob, 645 Broadway, Paterson
Stein, Harold M., 227 W. Broadway, Paterson

Stein, Harriet N., 620 Ridge rd., Lyndhurst
Steinberg, Benjamin L., 543 Main st., Singac
Stern, Morris H., Army
Stier, Howard W., 164 Jefferson st., Passaic
Stokes, James S., 32 Main st., Little Falls
Stoltz, Raymond R., 23 Passaic av., Passaic
Stouter, Francis L., 29 17th av., Paterson
Sucoff, Moses C., 158 Hamilton av., Passaic
Sullivan, William M., Jr., 43 Passaic av., Passaic
Surgent, George W., 168 Clifton av., Clifton
Sutherland, William W., 291 Highland av.,Ridgewood
Szymanski, John J., 616 Main av., Passaic
Taber, Leslie R., 292 Broadway, Paterson
Tarta, Ciro S., 641 E. 18th st., Paterson
Teichholz, Max H., 19 Meade av., Passaic
Tell, M. Edward, 249 Lexington av., Passaic
Thomas, Irene O., 350 Lafayette av., Hawthorne
Thomas, Leon H. S., 631 E. 22nd st., Paterson
Thompson, Edward C., 373 Park av., Paterson
Thorne, William P., 254 Main st., Butler
Thron, Leopold E., 586 E. 29th st., Paterson
Todd, Francis H., 83 Auburn st., Paterson
Tomkins, William, 105 Fairmount rd., Ridgewood
Tweddel, George K., 239 Broadway, Paterson
Udinsky, Hyman J., 57 Passaic av., Passaic
Vanderbeck, James J., Franklin av., Ridgewood
Vanderbeek, Andrew B., 174 Broadway, Paterson
Vanderbeek, Frank B., 407 Park av., Paterson
Vander Clock, Cornelius, 178 Gregory av., Passaic
Van Eerde, Albert, 339 Lafayette av., Hawthorne
Van Schott, Gerard J., Jr., 245 Lexington av., Passaic
Van Winkle, John S., 297 Broadway, Paterson
Vermeulen, Abram, 344 Haledon av., Prospect Park
Vernaglia, Anthony P., 418 Lincoln av., Hawthorne
Vosburgh, Fred, 663 Main av., Passaic
Vreeland, Ralph J., 278 McKinley pl., Ridgewood
Walker, Harold G., Everett av., Wyckoff
Wallace, Marc J., 165 Lakeview av., Clifton
Walton, Gordon G., 17 Church st., Paterson
Warburton, Jack C., 333 Park av., Paterson
Ward, Albert H., 404 Totowa av., Paterson
Warren, David E., 233 Gregory av., Passaic
Warren, Earl L., 266 Van Houten st., Paterson
Warren, Jacob, 308 18th av., Paterson
Wassing, Hans, 695 Broadway, Paterson
Weinert, Henry V., 128 Market st., Passaic
Weintraub, William L., 400 Broadway, Paterson
Weisman, Stephen L., 526 Broadway, Paterson
Westerhoff, Peter D., 51 Highland av., Midland Park
White, Richard E., Grandview av., R. D., Midl'dPark
Williams, Hiram, P. O. Box 272, Passaic
Winters, Walter M., 288 Broadway, Paterson
Wishnack, Meyer, 318 Broadway, Paterson
Wolf, Erich, 43 Grove st., Passaic
Wolf, Israel J., 231 East 31st st., Paterson
Wolfson, Harry, 356 Park av., Paterson
Wry, Dean A., 234 Dayton av., Clifton
Yachnin, Samuel C., 127 Prospect st., Passaic
Yager, J. Allen, 420 Broadway, Paterson
Yates, John S., 414 Ellison st., Paterson
Yeaw, Ralph C., 180 Carroll st., Paterson
Yolken, Harry, 246 E. 31st st., Paterson
Yorke, Benjamin, 908 Main st., Paterson
Zalewski, Irene J., 181 Paulison av., Passaic
Zick, Clara U., 60 Highland rd., Glen Rock
Zuckerman, David E., 568 Broadway, Paterson

ASSOCIATE MEMBERS

Alonzo, Gerard J., 477 Stuyvesant av., Lyndhurst
Aronsohn, Charles M., 429 Park av., Paterson
Beim, Norbert, 660 Broadway, Paterson
Carusi, Leonardo G., 337 Park av., Paterson
Ciccone, Roy, 57 Passaic av., Passaic
Cichon, Elmer J., 679 Van Houten av., Clifton
DeDominicis, Frank A., 811 E. 22nd st., Paterson
Edson, James, 676 Market st., Paterson
Ferrari, Salvatore, 374 21st av., Paterson
Friedmann, Gustav, 351 Totowa av., Paterson
Garzieri, Anthony, 444 Totowa rd., Totowa
Ged, Archie K., 1133 Main st., Paterson
Hathaway, George, Jr., 149 Prospect st., Passaic
Hochman, Alex, 269 Hamilton av., Paterson
Legg, George E., 666 Broadway, Paterson
Mabee, John R., 24 Center av., Little Falls
Manrodt, Kurt, Jr., Pompton Plains
Meer, Nadhim E., 400 Park av., Paterson
Nuzzolo, Charles A., 13 Lee pl., Paterson
Ozier, Charles W., 223 Autumn st., Passaic
Palmeri, Anthony, 47 Rowland av., Clifton
Pfeffer, Burton B., 46 Monroe st., Passaic
Pinck, Bernard, 161 Lexington av., Passaic
Ressetar, Michael, 455 Lexington av., Clifton
Rizzo, Ettore G., 184 Redwood av., Paterson
Salerno, Louis, 973 Van Houten av., Clifton
Santoro, Anthony, 45 Ward st., Paterson
Selikoff, Irving, 707 Broadway, Paterson
Shapiro, Joseph S., 375 Broadway, Paterson
Silver, Michael W., 718 E. 25th st., Paterson
Siss, Alfred A., 198 Haledon av., Prospect Park
Snell, Philip, 217 Paulison av., Passaic
Spinnler, Henry R., 242 Haledon av., Prospect Park
Sporer, Andrew, 707 Broadway, Paterson
Varhol, Joseph G., 436 Clifton av., Clifton
Weiner, Aaron, 68 N. 5th st., Paterson
Zigarelli, Joseph F., 273 E. 18th st., Paterson
Zuckerman, Louis, 568 Broadway, Paterson

COURTESY MEMBERS

Pearlman, Saul J., Paterson
Trilling, Leonard J., Paterson

HONORARY MEMBERS

Bergin, Joseph V., Paterson
Bullen, Victor E., Paterson
Crounse, David R., Passaic
Duncan, Owsley B., Paterson
Dunning, Walter L., Paterson
Flitcroft, William, Wisconsin
Maclay, Joseph A., Paterson
Neer, William, Ridgewood
Norval, William A., St. Petersburg, Fla.
Ritter, John J., Plainfield, Mass.
Scribner, Charles H., Preakness
Todd, Francis H., Paterson
Vanderbeek, Andrew B., Paterson
Yates, John S., Paterson

SALEM COUNTY (17)

Society organized May 4, 1880. Meets on the third Friday of each month, September to May, inclusive. Annual Meeting in April. Social Meeting in May.

ACTIVE MEMBERS

Bramble, Halsey S., Front & Chestnut sts., Elmer
Caggiano, John D., 165 W. Main st., Penns Grove
Chesler, Maurice, 124 W. Broadway, Salem
Cox, J. Robert, Army
Davison, C. Spencer, 7 Chestnut st., Salem
Davison, Wilbur S., 13 N. Broadway, Pennsville
Dunn, John S., 75 Market st., Salem
Evans, Edgar E., 12 Ziegler Tract, Penns Grove
Fleming, Charles L., 42 W. Main st., Penns Grove
Green, David W., 69 Market st., Salem
Hilliard, William T., 105 Market st., Salem
Jonas, August, 328 E. Broadway, Salem
Lipkin, Isadore, 157 W. Main st., Penns Grove
Lummis, Clarence P., 40 Delaware av., Penns Grove
Mackes, Claude B., 48 N. Main st., Woodstown
Mason, Alvin S., 26 Olive st., Salem
Miller, Lewis H., 37 S. Main st., Woodstown
Miller, William H., 7 Dickinson st., Woodstown
Neander, David G., 57 Chestnut st., Salem
Parker, Albert F., Army
Perry, Frank L., East av., Woodstown
Silverman, R. Louis, 21 W. Main st., Penns Grove
Suter, Harry F., 49 W. Main st., Penns Grove
Thomas, Claude W., 28 East av., Woodstown
Wetherhold, John M., 20 Ziegler Tract, Penns Grove
Zappala, John, 47 W. Main st., Penns Grove

SOMERSET COUNTY (18)

Society organized May 21, 1816. Meets on second Thursday evening of each month except July, August and September. Annual Meeting in June. Dinner Meeting in October.

ACTIVE MEMBERS

Albrecht, William J., 46 Grove st., Somerville
Allegrante, Anthony J.,WashingtonVal.rd.,Martinsv'e
Barbour, George E., 118 W. High st., Somerville
Borow, Henry, 507 Church st., Bound Brook
Borow, Maurice, 507 Church st., Bound Brook
Brittain, Elmore G., 4 E. High st., Bound Brook
Cameron, Albert, 10837 Sea Lane, Philadelphia, Pa.
Carlucci, Angelo M., N. J. State Village, Skillman
Case, Clarence E., Jr., 254 Altamount pl., Somerville
Chase, Anthony V., 654 Lincoln av., Manville
Cook, Caroline S., 27 E. Cliff st., Somerville
Cook, Homer E., 27 E. Cliff st., Somerville
Craig, Henry A., 315 William st., Somerville
Douglass, William C., 15 Olcott av., Bernardsville
Dresel, Irmgard, Mine Brook rd., Far Hills
Edelberg, Sidney S., 403 E. High st., Bound Brook
Ely, Lancelot, 128 W. High st., Somerville
Field, Frank L., Far Hills
Flint, Edgar T., 44 E. Somerset st., Raritan
Fritts, Lewis C., 118 West End av., Somerville
Galgoczy, Julius, Manville
Gentile, Ernest R., 125 Hamilton st., Bound Brook
Glass, George A., 282 E. Main st., Somerville
Gray, W. Burritt, 121 Somerset st., N. Plainfield
Greenberg, George A., 195 W. High st., Somerville
Hartmann, Edmund M., 122 Midway av., Fanwood
Hawkins, W., Veterans Administration, Lyons
Hegeman, Runkle F., 161 W. High st., Somerville
Hird, Emerson F., 118 E. Maple av., Bound Brook
Hochheimer, Arthur, 417 Somerset st., Bound Brook
Husted, Samuel H., Neshanic Station
Hyer, Godfrey S., 199 W. High st., Somerville
Jones, William F., N. Bridge st., Somerville
Kay, Clarence R., Main st. Peapack
Levy, Abram, 1401 Plainfield av., South Plainfield
Liddell, Raymond N., Leonardo
Marcus, Bernard, 6 S. Clark av., Somerville
McKinley, C. Scott, Bakelite Corp., Bound Brook
Misko Albert, 117 Westervelt av., N. Plainfield
Pauly, Arthur N., 297 W. Summit st., Somerville
Pigott, Albert W., N. J. State Village, Skillman
Pitman, Mason W. H., 17 Ross st., Somerville
Pogoloff, Samuel H., 68 N. First av., Manville
Reale, Nicholas P., Brooks blvd., Manville
Renner, Clara C., Blawenburg
Roecker, R., Veterans Administration, Lyons
Russo, Dominic T., 51 E. Somerset st., Raritan
Sanford, Marcus E., 41 W. High st., Somerville
Sargent, Eva R., 121 Myrtle av., North Plainfield
Saukimas, John, Calco Chemical Co., Bound Brook
Spaldo, John L., 32 Grove st., Somerville
Stolow, Alan A. J., 219 W. Summit st., Somerville
Tolomeo, Martin E., 5 E. High st., Bound Brook
Weitz, Paul, Veterans Administration, Lyons
Wender, Harold, 103 Clinton st., So. Bound Brook
Wolfsie, Jacob H., American Cyanamid Co., Linden
Young, James L., 68 Mountain av., Somerville

SUSSEX COUNTY (19)

Society organized August 22, 1829. Regular meetings in February, May, September and December at time, place and date designated by President and Secretary.

ACTIVE MEMBERS

Aitken, Herbert M., Ogdensburg
Bergmann, Ewald H., 44 Bank st., Sussex
Boyd, William B., Jr., N. J. Zinc Co., Franklin
Braun, David C., 51 Trinity st., Newton
Burn, Victor E., 27 Trinity st., Newton
Caleca, Jack J., Andover

Cartisser, Joseph J., Stanhope
Coleman, Joseph G., Hamburg
Drake, Leo B., 47 Main st., Franklin
Eddy, Lester R., 40 Bank st., Sussex
Hill, Dean F., Sussex
Johnson, George F., Branchville
Kirschner, Martin I., Vernon
Landes, Edwin W., Stillwater
Longnecker, John E., Jr., Sparta
Lushear, Frank H., Branchville
McCall, Jesse, 9 Linwood av., Newton
McVeigh, Charles J. D., Netcong
Morrison, Frederick H., 61 High st., Newton
Nester, John, 36 Halsted st., Newton
Patton, Paul B., 116 Main st., Newton
Pellet, Thomas L., Hamburg
Piampiano, John, 27 Vernon av., Hamburg
Roy, Bert W., 25 Hamburg av., Sussex
Schmidt, Clifford M., 81 Main st., Newton
Scott, Frederick J., 1 Oak st., Franklin
Spencer, James H., Jr., Newton
Spurgeon, Dorsett L., 19 Church st., Newton
Stewart, Katherine E., Railroad av., Ogdensburg
Vermes, Leslie, 380 Rutherford av., Franklin
Weinstein, Robert A., 214 Spring st., Newton
Weiser, Edward H., 1 E. Main st., Sussex

UNION COUNTY (20)

Society organized June 7, 1869. Meets on second Wednesday of September, November, January, March, April, and May. Annual Meeting in April.

ACTIVE MEMBERS

Abel, Henri E., 339 Union av., Elizabeth
Abramson, Solomon, 1118 Jagnes av., Rahway
Ackerman, Arthur F., 129 Summit av., Summit
Allen, Samuel L., 101 Union rd., Roselle Park
Anson, Leon J., 400 Center st., Garwood
Apfelbaum, Frederick M., 17 N. 10th st., Kenilworth
Armstrong, Lorrimer B., 121 S. Euclid av., Westfield
Arthur, Frances H., 138 Westfield av., Elizabeth
Axinn, Charles, 146 W. Gibbons st., Linden
Babbitt, Hugh M., Jr., 950 Park av., Plainfield
Baker, Raymond D., 52 De Forest av., Summit
Banker, George T., 1145 E. Jersey st., Elizabeth
Barberio, A. Arthur, 1337 Orange av., Union
Baron, Leo E., 26 Prospect pl., North Plainfield
Baruch, Hilde, 202 Stiles st., Elizabeth
Baruch, Rudolf J., 202 Stiles st., Elizabeth
Battaglia, Richard S., 323 Third av., Roselle
Bechet, Paul E., 1364 North av., Elizabeth
Beisler, Lawrence G., 1528 N. Broad st., Hillside
Bender, Dorothea A., 61 DeHart pl., Elizabeth
Bensley, Maynard G., 129 Summit av., Summit
Berenson, Samuel J., 1012 E. Jersey st., Elizabeth
Berger, Harold R., 250 Elizabeth av., Elizabeth
Berman, Leonard M., 128 Summit av., Summit
Berman, Sol, 351 Rahway av., Elizabeth
Berry, C. Hartley, 129 Summit av., Summit
Biber, David, 900 Stuyvesant av., Union
Black, Max S., 1320 St. George av., Linden
Blair, Thomas D., 414 Park av., Plainfield
Blatt, David, 137 Jefferson av., Elizabeth
Bloch, Harry, 613 N. Broad st., Elizabeth
Blumberg, Jack, 504 Westminster av., Elizabeth
Blythe, Rowland P., 30 Springfield av., Cranford
Boehm, Herbert, 804 E. Jersey st., Elizabeth
Bolanowski, Kasimier J., 145 Marshall st., Elizabeth
Booth, Walter S., 744 Rahway av., Elizabeth
Bourns, Edward G., 203 S. Euclid av., Westfield
Bowles, Harry H., 36 Woodland av., Summit
Boyd, Robert P., 210 Martine av., S., Fanwood
Boyer, Paul K., 129 Summit av., Summit
Boyes, James G., 1326 Chetwynd av., Plainfield
Braunwarth, Robert J., 555 S. Broad st., Elizabeth
Breslow, Alexander E., 930 Pierpont st., Rahway
Brethwaite, Samuel H., Jr., 129 Summit av., Summit
Brokaw, Christopher A., 1405 North av., Elizabeth
Brown, Frank H., Jr., 327 Chestnut st., Roselle Park
Brown, L. Greeley, 173 Madison av., Elizabeth
Brown, William H., 501 First av., Elizabeth
Bruno, Anthony, 1092 Elizabeth av., Elizabeth
Buchanan, Robert W., 129 Summit av., Summit
Buffey, Walter H., 19 Oakwood pl., Elizabeth
Burritt, Norman W., 30 Beechwood rd., Summit
Butenas, Joseph J., 300 First av., Elizabeth
Callahan, Edward J., 124 St. Paul st., Westfield
Cannis, John P., 1019 Park av., Plainfield
Canright, Cyril M., 34 Springfield av., Cranford
Cantini, Raphael S., 727 Watchung av., Plainfield
Card, Charles F., 144 W. Milton av., Rahway
Cardinale, Pasquale F., 654 E. Jersey st., Elizabeth
Carlisle, J. Mallory, 550 Hillcrest av., Westfield
Carpenter, Cedric C., 97 Hobart av., Summit
Carsley, Sidney H., 19 Holly st., Cranford
Casey, Robert B., 104 W. Milton av., Rahway
Casilli, Arturo R., 618 Newark av., Elizabeth
Castaldo, Neil, 103 Lincoln av., E., Cranford
Chaiken, Louis H., P. O. Box 51, Elizabeth
Chapman, Otis P., 125 Broad st., Elizabeth
Childers, Robert J., 604 Park av., Plainfield
Chodosh, Maurice A., 606 Roosevelt av., Carteret
Coe, Edward M., 217 Holly st., Cranford
Cohen, Harry X., 1243 Stuyvesant av., Union
Cole, Walter H., Jr., 1060 E. Jersey st., Elizabeth
Comunale, Anthony R., 1709 Irving st., Rahway
Conway, James V., 428 Elmora av., Elizabeth
Coplin, George J., 528 E. Jersey st., Elizabeth
Corbusier, Harold D., 612 Park av., Plainfield
Cox, William T. R., 345 S. Broad st., Elizabeth
Crabtree, Loren H., 505 Jersey av., Elizabeth
Crane, Norman T., 1025 Sleepy Hollow lane, Plainf'd
Cronin, Francis J., 730 South st., Elizabeth
Davidson, E. Norwell, 102 East Elm st., Linden
Davis, F. Cleveland, 129 Summit av., Summit
Davis, Stanton H., 212 E. Seventh st., Plainfield
Day, Willis B., 407 E. Seventh st., Plainfield
DeCesare, Ferdinand J., 500 Walnut st., RosellePark
Decker, Charles T., 275 Orchard st., Westfield
Deehl, Seymour R., 1026 E. Jersey st., Elizabeth
Demarest, Gerald B., 505 E. Broad st., Westfield
Dengler, Henry P., 260 Morris av., Springfield
Deutsch, Nathan S., 223 E. Fifth st., Plainfield
Diamond, J. George, 512 W. Front st., Plainfield
Doggett, E. Hugh, 805 Park av., Plainfield
Doherty, William, 830 N. Wood av., Linden
Dolsky, Irving, 509 N. Wood av., Linden
duBusc, L. C. Victor, 399 Westfield av., Elizabeth
Dudley, Henry G., 222 Sylvania pl., Westfield
Dunn, H. Irving, 610 Salem av., Elizabeth
Dupuy, Jean G., 850 Jersey av., Elizabeth

Durrah, Fred F., 310 Plainfield av., Plainfield
Dwoyer, Leon C., 420 N. Wood av., Linden
Eason, Samuel W., 48 De Forest av., Summit
Edgar, Malcolm S., 129 Summit av., Summit
Ehrlich, Max, 721 N. Broad st., Elizabeth
Esty, Geoffrey W., 629 E. Broad st., Westfield
Evans, Joseph O., 727 N. Wood av., Linden
Falconer-Slater, Kath., Four Winds, Kotonah, N. Y.
Feleppa, Edward E., 618 Springfield av., Summit
Ferenchak, Ralph, 219 Martine av., N., Fanwood
Fiedler, Michael J., 2368 S. W. 4th st., Miami, Fla.
Figliolino, Francis, 272 W. Milton av., Rahway
Fink, Stanley J., 268 E. 3rd av., Roselle
Fitch, Thomas S. P., 916 Park av., Plainfield
Forsberg, Roy T., 337 Bender av., Roselle Park
Fort, William B., 147 E. Seventh st., Plainfield
Foster, Frank L., 320 Springfield av., Cranford
Franklin, Joseph E., 191 North av., Hillside
Franklin, Lewis J., 149 Jean ter., Union
Freeman, Ray M., 2011 St. Georges av., Rahway
Friedburg, George H., 1108 Anna st., Elizabeth
Frohwein, Ida H., 125 Morristown rd., Elizabeth
Gadomski, Casimir F., 331 S. Broad st., Elizabeth
Gallaway, George E., 163 W. Milton av., Rahway
Gannon, Joseph M., 149 Crescent av., Plainfield
Geary, Paul, 909 Park av., Plainfield
Geib, Margaret E., 1227 Clinton pl., Elizabeth
Gerendasy, Julius, 956 E. Jersey st., Elizabeth
Giacona, Joseph, 221 Lincoln av., Union
Gibb, Alice S., 339 Union av., Elizabeth
Giglio, Alphonsus S. V., 626 Elizabeth av., Elizabeth
Gilpin, Fletcher, 118 North av., W., Cranford
Gittelman, Morton, 879 Newark av., Elizabeth
Glaser, Emanuel, 360 Linden av., Elizabeth
Glass, Benjamin E., 609 Watchung av., Plainfield
Glass, Harry L., 1009 Park av., Plainfield
Glassner, Frank, 308 Chestnut st., Roselle
Glasston, Hyman M., 628 N. Wood av., Linden
Golden, William M., 236 W. Milton av., Rahway
Goldfield, Harold H., 225 E. Jersey st., Elizabeth
Goldmacher, Herman B., 113 Elmora av., Elizabeth
Goldstein, Herman H., 318 W. Jersey st., Elizabeth
Gonczy, Edward J., 420 Jersey av., Elizabeth
Gordon, Norman W., 121 Third st., Elizabeth
Grant, William E., 1370 Morris av., Union
Greco, Lionel A., Bonnie Burn Sana., Scotch Plains
Greenberg, Max, 29 W. Henry st., Linden
Griesemer, Z. Lawrence, 1145 E. Jersey st., Elizab'th
Griswold, Merton L., Jr., 1415 Prospect av., Plainf'd
Guidi, Guido M., 212 Christine st., Elizabeth
Hackett, Daniel C., 319 Scotch Plains av., Westfield
Hall, Ralph A., 533 Boulevard, Westfield
Hall, Winthrop H., 400 Elm st., Westfield
Hallock, Wilton J., 650 Springfield av., Summit
Hamley, John J., 153 Second st., Elizabeth
Hanrahan, James, 678 N. Broad st., Elizabeth
Hansen, Harry, 916 Park av., Plainfield
Hanson, Carl G., 38 Springfield av., Cranford
Harris, Sidney, 301 W. Fifth st., Roselle
Hely, Charles J.,Jr., 564 Summit av., Westfield
Heminway, Norman L., 174 Summit av., Summit
Herrington, Lee R., 643 E. Broad st., Westfield
Hipple, Percy L., 118 E. Fifth av., Roselle
Hirsch, Lucien, 160 E. Seventh st., Plainfield
Hnat, Frederick, 565 Newark av., Elizabeth
Hoch, Samuel M., 240 Hillside rd. ,Elizabeth
Hoffman, Charles A., 302 E. Seventh st., Plainfield
Hoffman, Harry, 805 Park av., Plainfield
Holland, Reuben J., 1026 Chandler av., Linden
Holmes, Grace A., 1077 E. Jersey st., Elizabeth
Holt, Evelyn, 261 Springfield av., Summit
Horoschak, Anne, 974 Park av., Plainfield
Horre, George W. H., 203 W. Jersey st., Elizabeth
Hughes, Frederic J., 706 Park av., Plainfield
Humphrey, Hubert G., 430 Downer st., Westfield
Hunt, Thomas F., 528 Monroe av., Elizabeth
Hurtado, Edward, 763 Audrey dr., Rahway
Hutton, Frederick T., 717 Watchung av., Plainfield
Imbleau, Joseph E. L., 2106 Morris av., Unionville
Jacobs, Alan L., 254 Williamson av., Hillside
Johnson, Harold F., 734 Park av., Plainfield
Jones, Herbert E., 6 Hillside rd., Elizabeth
Jones, Lewis H., 139 E. Grant av., Roselle Park
Judd, Joseph, Jr., 300 Westfield av., Elizabeth
Kandra, Paul H., 153 Mountain av., Westfield
Kaplan, Samuel D., Army
Kapp, Carl G., 440 Westminster av., Elizabeth
Karel, Jack R., 407 Jersey av., Elizabeth
Karnay, Francis, 348 Pine av., Garwood
Karshmer, Ernest E., 420 Wood av., N., Linden
Katz, Theodore, 927 S. Wood av., Linden
Keeney, Cadwell B., 137 Summit av., Summit
Keil, Sigmund S., 1118 St. George av., E., Linden
Kemeny, George, 39 Third st., Elizabeth
Kennedy, John N., 831 Madison av., Plainfield
Kent, Louis R., 1974 St. Georges av., Rahway
Kidd, Ruth W., 2013 Morris av., Union
Klapper, Lester L., 421 W. Seventh st., Plainfield
Kloby, John J., 562 Bayway, Elizabeth
Knauer, George, 930 Elizabeth av., Elizabeth
Knight, Richard vanD., 129 Summit av., Summit
Konzelman, Henry J., 65 King st., Hillside
Kramer, Douglas W., 1019 Park st., Plainfield
Krans, Edward S., 920 Park av., Plainfield
Kreutz, Paul J., 363 Union av., Elizabeth
Kuchlewski, Edward J., 224 E. Jersey st., Elizabeth
Kushner, Alexander, 208 W. Milton av., Rahway
Kyle, Ernest I., 205 W. Ninth st., Plainfield
Labow, Joseph J., 757 N. Broad st., Elizabeth
Ladas, George, 305 Cherry st., Elizabeth
Lance, Elton W., 125 W. Milton av., Rahway
Landry, Ernest J., 729 Audrey dr., Rahway
Lane, Milton, 982 Stuyvesant ave., Union
Lang, Louis, 947 E. Jersey st., Elizabeth
Langston, Junius T., 521 E. Second st., Plainfield
Larrabee, Callie H., 24 Hobart av., Summit
Lathrop, Frederic W., 909 Park av., Plainfield
Lawrence, William H., 129 Summit av., Summit
Leggett, Lindley H., Jr., 330 E. Broad st., Westfield
Leggett, Thomas H., Jr., 706 Park av., Plainfield
Leone, Peter P., 27 Princeton rd., Elizabeth
Lepree, Joseph A., 45 Hillside rd., Elizabeth
Lerman, Frederick, 1024 E. Jersey st., Elizabeth
Lerman, Irving, 1024 E. Jersey st., Elizabeth
Lewis, Albert, 41 Retford av., Cranford
Lewis, Alexander, 113 W. Milton av., Rahway
Lieberman, David P., 597 Westminster av., Elizab'h
Lieberman, Milton L., 101 Pershing av., Roselle Pk.
Lilien, Milton M., 152 Clark st., Hillside
Linke, James J. P., 245 E. Front st., Plainfield
Lippincott, Lansing Y., 939 Park av., Plainfield
Livengood, Horace R., 587 Westminster av., Elizab'h
Losada, Camella A., 19 Prospect st., Summit
Lowell, Milton E., 434 Summit av., Westfield
Lowenstein, Ernest C., 259 W. Milton av., Rahway
Lufburrow, Charles B., 441 W. Front st., Plainfield
Lyerly, James M., 121 E. Seventh st., Plainfield
Lynch, Edward T., 748 Livingston rd., Elizabeth
Lynch, Michael F., 3 Palisade rd., Elizabeth
MacBrayer, Reuben A., Wee Dumfries, S'th'n P.,N.C.
MacDonald, Edward O., 719 Locust st., Roselle Park
Mackler, Harry S., 752 N. Broad st., Elizabeth
Maggio, Ross J., 206 Park av., Westfield
Malatesta, Charles S., 1203 Martine av., Plainfield
Mallison, Herbert, 819 Park av., Plainfield
Marone, Carmine R., 752 Newark av., Elizabeth
Maroney, James H., 129 Summit av., Summit
Martin, William E., 110 Clarement pl., Cranford

Marts, George H., 956 Park av., Plainfield
Mastroianni, Frank M., 634 Sherman av., Roselle Pk.
Maurer, Martha E., 133 Mountain av., Westfield
McAlpine, Paul, 129 Summit av., Summit
McCallion, Wm. H., 722 Westminster av., Elizabeth
McClintock, Elsie, 1439 Maple av., Hillside
McGinn, William J., 1913 Westfield av., ScotchPlains
Meeker, John L., 6 De Barry pl., Summit
Meineke, William C., Jr., 818 Chestnut st., Roselle
Mensch, Harvey G., 1117 Mary st., Elizabeth
Merlo, Francis A., 210 Murray st., Elizabeth
Merlo, Francis V., 33 Prince st., Elizabeth
Miller, George M., 288 Elm av., Rahway
Miller, Robert M., 382 Springfield av., Summit
Milliser, Estelle T., 126 N. Euclid av., Westfield
Mills, Stephen D., 132 S. Euclid av., Westfield
Minnella, Thomas J., 268 Springfield av., Summit
Mohr, Frank L., 560 Morris av.. Summit
Moon, Dabney vonK., 706 Park av., Plainfield
Morris, Karl E., 648 E. Broad st., Westfield
Morris, Thomas M., 505 Park av., Plainfield
Morris, Watson B., 193 Morris av., Springfield
Murphy, Albert T., 1108 Anna st., Elizabeth
Murphy, Herschel S., 320 Chestnut st., Roselle
Murray, Norman L., 129 Summit av., Summit
Nadler, Arthur A., Army
Naidorff, Saul A., 421 W. Seventh st., Plainfield
Nelson, Francis B., 275 Orchard st., Westfield
Neumann, Alfred, 432 Washington av., Linden
Nevius, John K., Jr., 1165 Park av., Plainfield
Newbury, Graham C., 209 Miln st., Cranford
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth
Novello, Joseph A., 641 Second av., Elizabeth
Nussbaum, Joseph, 321 Elmora av., Elizabeth
Obester, Gabriel E., 640 N. Broad st., Elizabeth
O'Brien, Edwin J., Jr., 1043 W. Eighth st., Plainfield
Oderr, Charles, 121 S. Euclid av., Westfield
Orton, Foster, 196 Elm av., Rahway
Orton, George L., 196 Elm av., Rahway
Orton, Stuart, 196 Elm av., Rahway
Osher, Morris M., 100 Martine av., N., Fanwood
Owen, Philip, 973 Salem rd., Union
Palin, George, 27A Wavecrest av., Winfield
Pearl, Sydney S., 837 Park av., Elizabeth
Peters, Richard C., 963 Park av., Plainfield
Phelan, Walter F., 124 Chilton st., Elizabeth
Pogge, Raymond C., 816 Central st., Plainfield
Poleshuck, Rubin, 100 Hollywood av., Hillside
Polk, Charles C., 114 E. Seventh av., Roselle
Pollack, Louis, 2052 Morris av., Union
Pollack, Sol, 2165 Morris av., Union
Prazak, Beatrice, 500 Monroe av., Elizabeth
Proudfoot, Perry A., 527 Walnut st., Roselle
Read, Jessie D., 519 Lenox av., Westfield
Reale, Frank P., 630 E. Second st., Plainfield
Reich, Jerome J., 1500 N. Broad st., Hillside
Reilly, David F., 44 Prince st., Elizabeth
Reiner, Jacob, 811 N. Broad st., Elizabeth
Reiter, Walter A., 50 DeForest av., Summit
Relyea, George M., 129 Summit av., Summit
Repta, Stephen, 2165 Morris av., Union
Robertson, Grace M., 515 W. Seventh st., Plainfield
Robinson, Anne W., 177 Outer dr., Oak Ridge, Tenn.
Rose, Abraham, 326 S. Broad st., Elizabeth
Rosenblatt, Max B., 150 Westfield av., Elizabeth
Rosenstein, Saivel L., 2120 Springfield av., Vauxhall
Rozett, Oscar, 19 Prospect st., Summit
Rubin, David, 200 E. Jersey st., Elizabeth
Rumsey, Wm. L., Jr., 766 Westfield av., Elizabeth
Runnells, John E., Bonnie Burn San., Scotch Plains
Sadoff, Joseph, 504 Westminster av., Elizabeth
Sager, Clifford J., 9 Garden dr., Roselle
Sagi, Ellen I., 376 Elmora av., Elizabeth
Salvati, Leo H., 275 Orchard st., Westfield
Satulsky, Emanuel M., 737 N. Broad st., Elizabeth
Sauerbrun, Bertram J. L., 681 Newark av., Elizabeth
Scalessa, Mario F. T., 396 Broad st., Summit
Schenk, Joseph R., 1177 Park av., Plainfield
Schiller, Edwin, 523 Westfield av., Elizabeth
Schiller, Rosa O., 523 Westfield av., Elizabeth
Schilling, Anthony B., 727 Jefferson av., Elizabeth
Schlein, David, 812 N. Wood av., Linden
Schlichter, Charles H., 556 N. Broad st., Elizabeth
Schwartz, Samuel H., 916 Park av., Plainfield
Schweizer, Roman G., 36 Summit rd., Elizabeth
Seeler, Albert O., 64 Royce rd., Newton Ctr., Mass.
Seidmon, Edward E., 221 W. Seventh st., Plainfield
Sell, Frederick W., 167 W. Emerson av., Rahway
Senerchia, Fred F., Jr., 457 Union av., Elizabeth
Seybold, Arthur D., 1080 Rahway rd., Plainfield
Seymour, George A., 253 Orchard st., Elizabeth
Shangle, Milton A., 34 Prince st., Elizabeth
Shapiro, Max, 414 Elizabeth av., Elizabeth
Sheedy, John J., 121 E. Seventh st., Plainfield
Shirrefs, Russell A., 348 Elmora av., Elizabeth
Silverman, Theodore M., 105 Elmora av., Elizabeth
Sims, Richard V., Jr., 31 Morris av., Summit
Singer, Bella, 640 Wyoming av., Elizabeth
Sly, John L., 382 Springfield av., Summit
Sordillo, Anthony, 1114 Grandview av., Westfield
Speer, Charles A., 19 Holly st., Cranford
Spirito, Michael W., 219 S. Broad st., Elizabeth
Spivack, David, 315 W. Jersey st., Elizabeth
Spivack, Seymour E., 405 Chestnut st., Roselle
Staub, E. Milton, 505 E. Broad st., Westfield
Steele, Stephen, 10 West Gibbons st., Linden
Stein, Emil, 607 Park av., Elizabeth
Stein, George H., 640 Wyoming av., Elizabeth
Stein, Isadore, 817 N. Broad st., Elizabeth
Stein, Martin H., 60 Elmora av., Elizabeth
Steinberg, Werner, 45 E. Henry st., Linden
Stephenson, Gordon A., 145 Summit av., Summit
Stevenson, G. McKay, 129 Summit av., Summit
Strauss, Clifton J., 51 De Forest av., Summit
Strelinger, Alexander, 650 N. Broad st., Elizabeth
Strom, Abraham, 410 W. Seventh st., Plainfield
Stuart, J. Earle, 552 E. Second st., Plainfield
Stybel, Joseph, 503 Park av., Plainfield
Suffness, Gustave, 980 Park av., Elizabeth
Tator, Arthur E., 57 DeForest av., Summit
Terrell, Edward E., 16 Alden st., Cranford
Thompson, Minturn R., 530 W. Broad st., Westfield
Thompson-Bohne, Mildred H., 62 Elm st., Summit
Tidaback, John D., 382 Springfield av., Summit
Tolor, Stanley, 405 Westminster av., Elizabeth
Tomlinson, Rolland D., 505 E. Broad st., Westfield
Townsend, Leslie M., 420 Chestnut st., Roselle Park
Trano, Giovanni, 941 E. Jersey st., Elizabeth
Triarsi, Anthony J., 702 Third av., Elizabeth
Tyndall, Alice E., 263 Walnut st., Westfield
Tyndall, Martha W., 263 Walnut st., Westfield
Vinciguerra, Michael, 604 Westminster av., Elizab'h
Vitale, Dominic V., 749 N. Broad st., Elizabeth
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
Wacker, William F., 1224 Salem av., Hillside
Wade, Simon F., 555 Newark av., Elizabeth
Wagner, Richard, 915 Springfield av., N. Providence
Walsh, Ronald J., 338 S. Broad st., Elizabeth
Walsh, Thomas J., 335 S. Broad st., Elizabeth
Ward, Leo J., 137 W. Jersey st., Elizabeth
Webb, Eleanor A., 887 Springfield av., Summit
Wegryn, Louis S., 257 Elizabeth av., Elizabeth
Weigel, Edgar W., 210 W. Jersey st., Elizabeth
Weigel, Elmer P., 727 Watchung av., Plainfield
Welssberg, Willlam W., 253 W. 72nd st., N. Y. C.
Weissman, Meyer T., 1137 E. Jersey st., Elizabeth
Weltz, Abraham, 20 N. 18th st., Kenilworth
Weltchek, Herbert, 240 Lincoln av., Elizabeth

Whitken, Albert I., 1056 North av., Elizabeth
Willetts, Arthur T., 129 Summit av., Summit
Williams, Frank A., 324 W. Jersey st., Elizabeth
Williams, Leonard D., 726 Watchung av., Plainfield
Williams, Manley C., Navy
Wolff, Jerome M., 1414 Martine av., Plainfield
Wolgin, Philip L., 445 Elmora av., Elizabeth
Woody, McIver, 19 Pingry pl., Elizabeth
Wuester, William O., 238 Exter way, Hillside
Yarnell, Helen, 111 E. Front st., Plainfield
Yellin, Charles H., 525 E. Second av., Roselle
Yood, Harold S., 401 Grant av., Plainfield
Yorke, Edward T., 2300 Summit ter., Linden
Young, Franklin C., 120 Summit av., Summit
Young, Ralph A., 842 N. Wood av., Linden
Yuckman, Robert O., 701 Madison av., Elizabeth
Zeitlin, Herman H., 943 N. Wood av., Linden
Zingales, Joseph A., 101 Holly st., Cranford
Zirpolo, Gene A. V., 1128 Bryant st., Rahway

HONORARY MEMBERS

Guidi, Guido M., Elizabeth
Shirrefs, Russell A., Elizabeth

WARREN COUNTY (21)

Society organized February 15, 1826. Meets on third Tuesday of January, April, July and October, the last being the Annual Meeting.

ACTIVE MEMBERS

Adler, Hubert J., 91 Morris av., Phillipsburg
Baldauf, Herman, Jr., Greenwich st., Belvidere
Bartolini, Frank, 122 Belvidere av., Washington
Bloom, G. Homer, Hillcrest av., Phillipsburg
Boquist, Walter A., 380 Hudson st., Phillipsburg
Bossard, Harry B., R. D. 2, Phillipsburg
Bostwick, Wallace R., Main st., Blairstown
Brasefield, Edgar N., 218 Chambers st., Phillipsburg
Buchanan, Ralph M. L., 8 Market st., Phillipsburg
Cioffi, Eugene, 137 Belvidere av., Washington
Drake, Paul F., 85 Summit av., Phillipsburg
Gordon, Frank S., Blairstown
Humbert, Joseph C., Jr., Stewartsville
Jackson, Elmer C,. Blair Academy, Blairstown
Kassow, Philip B., North Blvd., Alpha
Kimmel, Seymour S., Oxford
Krausz, Emery, 577 S. Main st., Phillipsburg
Lemmon, Junius M., 28 W. W'sh'gt'n av.,Wash'gt'n
Marlett, Neumann C., 230 Greenwich st., Belvidere
Michell, George E., 221 High st., Hackettstown
Potter, Charles W., 184 Belvidere av., Washington
Ringe, Charles L., Jr., Blairstown
Shevitz, David M., 212 Grand av., Hackettstown
Shimer, Floyd A., 88 Lewis st., Phillipsburg
Smith, Herman, 306 Bates st., Phillipsburg
Spillane, Timothy H., 379 S. Main st., Phillipsburg
Stanowicz, Stefan J., Hackettstown
Varney, William H., 122 Belvidere av., Washington
West, Guernsey F., 109 S. Main st., Phillipsburg
Wolf, Frank A., 494 S. Main st., Phillipsburg
Zuck, Arthur C., 22 Broad st., Washington

MEMBERSHIP SUMMARY

County	Total		In Service	
	Active	Associate	Active	Associate
Atlantic	131	15	4	2
Bergen	313	47	8	..
Burlington	74	..	..	..
Camden	228	..	..	..
Cape May	33	..	..	..
Cumberland	61	..	..	..
Essex	1229	110	32	5
Gloucester	37	..	1	..
Hudson	471	..	6	..
Hunterdon	33	..	1	..
Mercer	246	34	1	..
Middlesex	177	36	1	..
Monmouth	147	25	1	..
Morris	138	..	..	..
Ocean	30	..	..	..
Passaic	418	38	6	..
Salem	26	..	2	..
Somerset	57	..	..	..
Sussex	32	..	..	..
Union	413	..	3	..
Warren	31	..	..	..
	4325	305	66	7

THE NEW JERSEY DOCTOR'S ALMANAC

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HENRY C. BARKHORN, M.D., Chairman
HENRY A. DAVIDSON, M.D., Editor

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GENERAL HOSPITALS IN NEW JERSEY

Following is a list of *general* hospitals in New Jersey registered with the Council on Medical Education and Hospitals of the American Medical Association. Data are derived from official Council reports.

This is a roster of general hospitals. It excludes therefore all specialized institutions, such as tuberculosis sanatoria, orthopedic hospitals, institutions for psychiatric disorders, maternity homes, isolation hospitals and the like. Also excluded are infirmaries of universities, prisons, plants and organizations as well as army and navy hospitals.

Specialized hospitals are listed on page 68.

In this list of general hospitals, the arrangement is alphabetically by counties; and within counties, by cities. Numeral in parentheses indicates number of beds.

Atlantic County

Atlantic City
* † Atlantic City Hospital (260)

Somers Point
Shore Memorial Hospital (65)

Bergen County

Engelwood
* † Engelwood Hospital (196)

Hackensack
* † Hackensack Hospital (250)

Teaneck
* † Holy Name Hospital (185)

Burlington County

Mount Holly
* † Burlington County Hospital (127)

Riverside
† Zubrugg Memorial Hospital (41)

Camden County

Blackwood
Camden County General Hospital (250)

Camden
† Camden General Hospital (30)
* † Cooper Hospital (351)
* † West Jersey Homeopathic (262)

Cumberland County

Bridgeton
† Bridgeton Hospital (93)

Millville
† Millville Hospital (52)

Vineland
Newcomb Hospital (85)

Essex County

East Orange
* † East Orange General Hospital (120)

Irvington
† Irvington General Hospital (115)

Montclair
† Community Hospital (56)
* † Mountainside Hospital (309)
St. Vincent's Hospital (51)

Newark
American Legion Memorial Hospital (35)
* † Beth Israel Hospital (365)
† Columbus Hospital (75)
† Community Hospital (26)
* Newark City Hospital (700)
* † Lutheran Memorial Hospital (104)
* † Presbyterian Hospital (271)
* † St. Barnabas Hospital (225)
* † St. James Hospital (137)
* † St. Michael's Hospital (350)

Orange
* † Orange Memorial Hospital (364)
* † St. Mary's Hospital (125)

Gloucester County

Woodbury
† Underwood Hospital (65)

Hudson County

Bayonne
* † Bayonne Hospital (250)
Swiney Sanatorium (16)

Hoboken
* † St. Mary's Hospital (421)

Jersey City
* † Christ Hospital (240)
† Fairmount Hospital (60)
† Greenville Hospital (60)
* † Jersey City Hospital (900)
* St. Francis Hospital (228)

* Approved for internship.
† Participates in Blue Cross Plan.

Kearny
† West Hudson Hospital (64)

Secaucus
Hudson County General Hospital (224)

Union City
Union City General Hospital (40)

Weehawken
* † North Hudson Hospital (166)

Mercer County

Princeton
Isabella McCosh Infirmary (55)
† Princeton Hospital (85)

Trenton
* † McKinley Hospital (128)
* † Mercer Hospital (240)
* † St. Francis Hospital (330)
† Trenton General Hospital (52)

Middlesex County

New Brunswick
† Middlesex General Hospital (100)
* † St. Peter's Hospital (194)

Perth Amboy
* † General Hospital (163)

South Amboy
Memorial Hospital (35)

Monmouth County

Allentown
† Dr. Farmer's Hospital (40)

Long Branch
† E. C. Hazard Hospital (95)
* † Monmouth Memorial Hospital (254)

Neptune
* † Fitkin Memorial Hospital (150)

Red Bank
† Riverview Hospital (40)

Morris County

Dover
† Dover General Hospital (108)

Morristown
* † All Soul's Hospital (125)
* † Morristown Memorial Hospital (138)

Ocean County

Lakewood
Paul Kimball Hospital (65)

Pinewald
Royal Pines (85)

Point Pleasant
† Point Pleasant Hospital (48)

Passaic County

Passaic
† Beth Israel Hospital (77)
* † Passaic General Hospital (225)
* † St. Mary's Hospital (190)

Paterson
* † Barnert Hospital (116)
* † Paterson General Hospital (384)
* † St. Joseph's Hospital (390)

Somerset County

Bound Brook
† Bound Brook Hospital (34)

Somerville
† Somerset Hospital (96)

Sussex County

Franklin
Franklin Hospital (37)

Newton
† Memorial Hospital (42)

Sussex
Alexander Linn Hospital (23)

Union County

Elizabeth
* † Alexian Brothers Hospital (168)
* † Elizabeth General Hospital (197)
* † St. Elizabeth's Hospital (216)

Plainfield
* † Muhlenberg Hospital (270)

Rahway
† Rahway Memorial Hospital (80)

Summit
† Overlook Hospital (158)

Warren County

Philipsburg
† Warren Hospital (65)

* Approved for internship.
† Participates in Blue Cross Plan.

SPECIAL HOSPITALS IN NEW JERSEY

Following is a list of the special hospitals in the state registered with the American Medical Association. Data are derived from the "Hospital Number" of the JOURNAL of the American Association.

The numeral in parentheses indicates the number of beds.

For information about acceptable residencies in New Jersey, see page 71 of this ALMANAC.

The following list is divided into 8 sections:

(1) Isolation Hospitals
(2) Maternity Hospitals
(3) Children's Hospitals
(4) Institutions for mental disease
(5) Orthopedic Hospitals
(6) Institutions for chronics and convalescents
(7) Tuberculosis hospitals
(8) Colonies for mental defectives

In addition to institutions in these eight specialized categories, New Jersey has one hospital specially devoted to *ophthalmology and otolaryngology* and one colony for *epileptics*. The latter is the New Jersey State Village, at Skillman, and the former is the Eye and Ear Infirmary in Newark.

(1) Isolation Hospitals

Atlantic County, Atlantic City, Municipal Hospital (68)

Bergen County, Ridgewood, Bergen Pines (476)

Camden County, Camden, Municipal Hospital (100)

Essex County, Belleville, Isolation Hospital (360)

Hudson County, Secaucus, Hospital for Contagious Diseases (176)

Mercer County, Trenton, Donnelly Memorial Hospital (420)

Passaic County, Paterson City Hospital (110)

(2) Maternity Hospitals

Jersey City, Margaret Hague Hospital (345)

Jersey City, Door of Hope (Salvation Army) (61)

Newark, Florence Crittenton Home (27)

(3) Children's Hospitals

Morris Plains, Victoria Foundation (24)

Camden, Marion Childs Hospital (26)

Newark, Babies' Hospital (70)

(4) Institutions for Mental Disease

Federal Institution: Veterans Hospital at Lyons (in Somerset County) (2741)

State Institutions: State Hospitals at Trenton (3000); at Marlboro (2913), and at Greystone Park (6507). See page 80 this ALMANAC.

County Institutions: Atlantic County, at Northfield (475); Burlington County, at New Lisbon (300); Camden County, at Blackwood (750); Cumberland County, at Bridgeton (300); Essex County, at Cedar Grove (Overbrook) (2643); Hudson County at Secaucus (2000). See page 79 this ALMANAC for further details.

Private Institutions: Christian Sanatorium (165) at Wyckoff, in Bergen County; Mount View Rest (20) at Roseland, in Essex County; Glenwood Sanatorium (25) in Trenton; Belle Mead Sanatorium (65) at Belle Mead, in Somerset County; Fair Oaks (42) at Summit, in Union County.

(5) Orthopedic Hospitals

Atlantic City, Children's Seashore House(146)

Hasbrouck Heights, Hasbrouck Heights Hospital (31)

Newark, Hospital and Home for Crippled Children (110)

Orange, N. J. Orthopedic Hospital (41)

Trenton, Orthopedic Hospital (45)

Westfield, Children's Country Home (50)

NOTE: The institutions at Atlantic City, Camden, Trenton and Paterson are city hospitals; the others are county institutions.

(6) Institutions for Chronics and Convalescents

Cumberland County, Vineland, New Jersey Soldier's and Sailor's Home (62)

Essex County, Caldwell, Teresa Grotta Home (40)

Essex County, Newark Convalescent Hospital (150)

Middlesex County, Menlo Park, State Home for Disabled Soldiers (100)

Morris County, Morristown, Aurora Institute (90)

Passaic County, Paterson, Hope Dell (125)

Union County, Westfield, Brookside Nursing Home (30)

NOTE: The institutions at Caldwell, Morristown and Westfield are privately operated. The others are city, county or state institutions.

(7) Tuberculosis Hospitals

Atlantic County Hospital for Tuberculosis Diseases at Northfield (86)

Bergen County, Ridgewood, Bergen Pines (476)

Burlington County, Browns Mills, Deborah Sanatorium (96)

Burlington County, New Lisbon, Fairview Sanatorium (112)

Camden County Tuberculosis Hospital at Grenlich (250)

Essex County, Verona, Essex Mountain Sanatorium (446)

Hudson County, Jersey City, B. S. Pollak Hospital (477)

Hunterdon County, Glen Gardner, New Jersey Sanatorium (474)

Mercer County, Donnelly Memorial Hospital in Trenton (420)

Middlesex County, Metuchen, Roosevelt Hospital (221)

Monmouth County, Allenwood Sanatorium (100)

Morris County, Morristown, Shogum Sanatorium (76)

Morris County, Newfoundland, Idylease (50)

Passaic County, Paterson, Valley View (234)

Union County, Scotch Plains, Bonnie Burn (428)

NOTE: The Donnelly Memorial Hospital is city-operated. Deborah and Idylease are private institutions. The sanatorium at Glen Gardner is a state institution. The others listed above are county hospitals.

(8) Colonies for mental defectives

For *males*: State colonies at New Lisbon and Woodbine.

For *females*: State colonies at Vineland and Totowa.

See page 80, this ALMANAC for further details.

SPECIAL GOVERNMENT-OPERATED HOSPITALS

1. Mental Disease.
2. Mental Deficiency.
3. Tuberculosis.
4. Contagious Diseases.
5. Chronic Diseases.
6. Epileptics.

1. Mental Diseases

AUTHORITY	NAME	CHIEF EXECUTIVE	POST OFFICE ADDRESS
Veterans Adm.	Veterans Adm. Hospital	Dr. H. E. Foster	Lyons
State of N. J.	State Hospital	Dr. M. A. Curry	Greystone Park
State of N. J.	State Hospital	Dr. J. B. Gordon	Marlboro
State of N. J.	State Hospital	Dr. J. B. Spradley	Trenton 8
Atlantic County	Mental Disease Hosp.	Dr. Edward Guion	Northfield
Burlington County	Hosp. for Insane	Mr. W. T. Stewart	New Lisbon
Camden County	Hosp. for Ment. Diseases	Miss M. F. Hess	Blackwood
Cumberland County	Mental Disease Hosp.	Mr. R. G. Riggins	Ridgeton
Essex County	Hospital at Overbrook	Dr. H. G. Smith	Cedar Grove
Hudson County	Hosp. for Ment. Diseases	Dr. R. J. Lynch	Secaucus

2. Mental Deficiency

State of N. J.	State School (females)	Mr. G. B. Thorn	Vineland
State of N. J.	N. J. Training School (females)	Mr. A. H. Meese	Box 215, Little Falls
State of N. J.	State Colony (males)	Dr. C. T. Jones	New Lisbon
State of N. J.	State Colony (males)	Mr. E. L. Johnstone	Woodbine

Authority	Name	Chief Executive	Post Office Address

3. Tuberculosis

State of N. J.	San. for Tuberculous Diseases	Dr. S. B. English	Glen Gardner
Atlantic County	Pine Rest TB. Sanatorium	Mr. L. Conover	Northfield
Bergen County	Bergen Pines	Dr. R. R. Little	Ridgewood
Burlington County	Fairview Sanatorium	Dr. M. W. Newcomb	New Lisbon
Camden County	Lakeland TB. Sanatorium	Dr. M. H. Collier	Blackwood
Essex County	Essex Mountain Sanatorium	Dr. A. M. Hicks	Verona
Essex County	Hosp. for Tuberc. Children	Dr. E. L. Smith	Belleville
Hudson County	B. S. Pollak Hospital	Dr. B. S. Pollak	Jersey City
Middlesex	Roosevelt Hospital	Dr. H. J. White	Metuchen
Monmouth	County Sanatorium	Miss E. Hynes	Allenwood
Morris	Shonghum TB. Sanatorium	Dr. H. S. Hatch	Morristown
Passaic	Valley-View Tuberculosis San.	Dr. H. H. Cherry	Paterson
Union	Bonnie Burn, TB. San.	Dr. J. E. Runnels	Scotch Plains
City of Trenton	Donnelly Memorial Hosp.	Mr. W. A. Burns	Trenton

4. Contagious Diseases

Bergen County	Isolation Hospital	Dr. R. R. Little	Oradel
Essex County	Contagious Dis. Hosp.	Dr. E. L. Smith	Belleville
Hudson County	Contagious Dis. Hosp.	Miss E. Kavanaugh	Secaucus
City of Atlantic City	Municipal Hospital	Dr. S. Salasin	Atlantic City
City of Camden	Municipal Hospital	Dr. J. C. Lovett	Camden
City of Jersey City	Jersey City Hosp.	Dr. G. O'Hanlon	Jersey City
City of Trenton	Donnelly Memorial Hosp.	Mr. W. A. Burns	Trenton
City of Passaic	Municipal Hospital	Dr. H. E. Dwyer	Passaic
City of Paterson	Municipal Hospital	Mr. T. Tonge	Paterson
City of Elizabeth	Isolation Hospital	Mr. L. J. Richards	Elizabeth

5. Chronic Diseases

State of N. J.	Home for Disabled Soldiers	Mr. W. R. McCrosson	Vineland
State of N. J.	Home for Disabled Soldiers	Mr. W. M. Thompson	Menlo Park
Atlantic County	Alms House	Dr. E. Guion	Northfield
Bergen County	County Home	Mr. B. Dansen	Oradell
Burlington County	Welfare Home	Mr. W. I. Leonard	New Lisbon
Camden County	General Hospital	Mrs. M. C. Gray	Blackwood
Cape May County	County Home	Mrs. E. Sprinzer	Cape May C. H
Cumberland County	County Farm	Mr. L. I. Bonham	Bridgeton
Gloucester County	County Institution	Mr. W. Feltman	Clarksboro
Hudson County	Almshouse	Mr. A. Dorn	Secaucus
Middlesex County	County Hospital	Miss K. Mabey	New Brunswick
Monmouth County	Welfare House	Miss M. Crawford	Freehold
Morris County	Welfare Home	Miss M. S. Wilson	Morris Plains
Passaic County	Hope Dell	Mr. R. K. Robertson	Preakness
Salem County	Alms House	Mr. F. B. Biddle	Woodstown
Sussex County	Welfare Home	Mrs. L. Griffin	Newton RD 3
Warren County	Welfare House	Mrs. G. Seals	Oxford
City of Newark	Alms House	Mr. J. H. Farmer	Newark 6
City of Orange	City Home	Mr. Richard Quinn	Livingston
City of Jersey City	Jersey City Hospital	Dr. G. O'Hanlon	Jersey City
City of Trenton	Municipal Colony	Mr. W. A. Burns	Trenton
City of Paterson	City Hospital	Mr. T. A. Tonge	Paterson

6. Epileptics

State of N. J.	State Village	Dr. A. W. Pigott	Skillman

RESIDENCIES IN NEW JERSEY

Evaluation of residencies is still in a state of flux. Some hospitals have only a "temporary" approval, while others (not here listed) are in the process of developing residencies which will later be added to the approved index. The institutions named below are considered, as of January 1947, to be offering acceptable residency training in accordance with the standards of the American Medical Association. Numerals indicate the number of approved residencies.

Anesthesia:
2—West Jersey Homeopathic (Camden)
6—Jersey City Hospital

Chest Surgery: 1—Hudson County Tuberculosis Hospital

Communicable Diseases: 7—Essex County Isolation Hospital (Belleville)

Gynecology: 4—Jersey City Hospital

Internal Medicine: 7—Jersey City Hospital

Malignant Diseases: 2—Jersey City Hospital

Obstetrics:
2—Cooper Hospital (Camden)
14—Margaret Hague Maternity Hospital (Jersey City)

Ophthalmology:
3—Jersey City Hospital
2—Eye and Ear Infirmary (Newark)

Orthopedics:
1—Hospital and Home for Crippled Children (Newark)
6—Jersey City Hospital
2—Monmouth Memorial Hospital (Long Branch)
3—Orange Orthopedic Hospital
1—Trenton Orthopedic Hospital

Otolaryngology:
2—Eye and Ear Infirmary (Newark)
3—Jersey City Hospital
1—Newark City Hospital

Pathology:
1—Atlantic City Hospital
1—Jersey City Hospital
2—Newark Beth Israel Hospital
1—Paterson General Hospital

Pediatrics:
1—Babies Hospital (Newark)
3—Jersey City Hospital
1—St. Michael's Hospital (Newark)

Plastic Surgery:
2—St. Barnabas (Newark)

Psychiatry: New Jersey State Hospitals at Greystone Park (13), Marlboro (7) and Trenton (2)

Radiology:
1—Atlantic City Hospital
1—Newark Beth Israel Hospital

Surgery:
2—Atlantic City Hospital
1—Burlington County Hospital (Mt. Holly)
2—Cooper Hospital (Camden)
1—Hackensack Hospital
6—Jersey City Hospital
1—Mountainside Hospital (Montclair)
1—Newark Beth Israel Hospital
1—West Jersey Homeopathic Hospital (Camden)

Tuberculosis:
9—Essex Mountain Sanatorium (Verona)
5—Hudson County Tuberculosis Hospital (Jer- City)
3—New Jersey Sanatorium (Glen Gardner)

Urology:
1—Atlantic City Hospital
3—Bayonne Hospital
4—Jersey City Hospital
1—Newark City Hospital

SPECIALTY EXAMINING BOARDS

Inquiries as to the status of newly developed residencies should be directed to the Council on Medical Education and Hospital of the American Medical Association at 535 North Dearborn Street, Chicago 10. Physicians applying to the American Boards should write directly to the Board secretary for an opinion as to the acceptability of specified residencies. Sometimes Boards will accept a residency for only six months or one year's credit even though the term of service may be longer. The names and addresses of the Board secretaries follow:

Anesthesiology: Dr. Paul M. Wood, 745 Fifth Ave., New York 22, N. Y.

Dermatology: Dr. George M. Lewis, 66 East 66th St., New York, N. Y.

Gynecology: Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pa.

Internal Medicine: Dr. William A. Werrell, 1 West Main st., Madison 3, Wis.

Neurology: Dr. Francis J. Braceland, 102 Second Ave., SW, Rochester, Minn.

Neuro-surgery: Dr. Paul C. Bucy, 912 South Wood St., Chicago 12.

Obstetrics: Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pa.

Ophthalmology: Dr. S. J. Beach, 56 Ivie Rd., Cape Cottage, Me.

Orthopedics: Dr. F. M. McKeever, 1136 West Sixth St., Los Angeles 14, Cal.

Otolaryngology: Dr. Dean M. Lierle, University Hospital, Iowa City, Ia.
Pathology: Dr. F. W. Hartman, Henry Ford Hospital, Detroit, Mich.
Pediatrics: Dr. Lee F. Hill, 3309 Forest Ave., Des Moines, Ia.
Plastic Surgery: Dr. James Barrett Brown, 400 Metropolitan Building, St. Louis 3, Mo.
Psychiatry: Dr. F. J. Braceland, 102 Second Ave., SW, Rochester, Minn.
Radiology: Dr. B. R. Kirklin, 102 Second Ave., SW, Rochester, Minn.
Surgery: Dr. J. Stewart Rodman, 225 South 15th St., Philadelphia, Pa.
Syphilology: Dr. George M. Lewis, 66 East 66th St. New York City.
Urology: Dr. G. J. Thomas, 1409 Willow St., Minneapolis, Minn.

STATE AGENCIES CONCERNED WITH HEALTH

State Department of Health, Room 232, State House, Trenton 8.
State Department of Institutions and Agencies, 135 West Hanover Street, Trenton 7.
Health and Safety Division of State Department of Public Instruction, Room 1302, at 28 W. State Street, Trenton 8.
State Crippled Children's Commission, Room 732, at 143 East State Street, Trenton 8.
New Jersey Rehabilitation Commission, Room 735, at 143 East State Street, Trenton 8.
Alcoholic Beverage Commissioner, 1060 Broad Street, Newark 2.
State Board of Children's Guardians, 163 West Hanover Street, Trenton 8.
State Board of Medical Examiners, Room 1101, at 28 West State Street, Trenton 8.
State Department of Motor Vehicles, State House Office Building, Trenton.
State Board of Pharmacy, 28 West State Street, Trenton 8.
State Board of Examiners for Nurses, 17 Academy Street, Newark 2.
Department of Labor, 1060 Broad Street, Newark 2.

STATE ORGANIZATIONS CONCERNED WITH HEALTH

The Medical Society of New Jersey, 315 West State Street, Trenton 8.
N. J. Health and Sanitary Association, 3 Morris Street, Freehold.
N. J. Health Officers Association, Thomson Hall, Princeton.
State Nurses Association, Room 1112, at 17 Academy Street, Newark
N. J. Hospital Association, Medical Center, Jersey City 4.
N. J. Pharmaceutical Association, Room 318, at 28 West State Street, Trenton 8.
State Dental Society, 223 East Hanover Street, Trenton 8.

SPECIALTY SOCIETIES IN NEW JERSEY

Following is a roster of specialists' organizations in New Jersey. The list is based on material submitted by the various societies for publication in the JOURNAL.

The name and address of the officer who handles correspondence for each society, is indicated parenthetically. This is usually the secretary.

Anesthesia: N. J. State Society of Anesthesiologists. (Dr. A. L. Dear, 23 Synott Place, Newark 6).
Clinical Pathology: N. J. Society of Clinical Pathologists. (Dr. A. R. Abel, Orange Memorial Hospital, Orange, N. J.)
Diabetes: New Jersey Diabetes Association. Dr. B. Saslow, 102 Shanley Avenue, Newark 8).
Gastro-Enterology: N. J. Gastro-enterological Society. (Dr. A. J. Statman, 17 Leslie Street, Newark 8.)
Gynecology: See "obstetrics" below.
Industrial Medicine: N. J. Association of Industrial Physicians. (Dr. Augustus Gibson, Secretary, Mendham, N. J.)
Internal Medicine: N. J. Chapter of American College of Chest Physicians. (Dr. P. K. Bornstein, 320 Asbury Avenue, Asbury Park.)
Also see: *Gastro-Enterology,* above.
Neurology: N. J. Neuropsychiatric Association. (Dr. D. J. Flicker, 82 Clinton Avenue, Newark 5.)
Obstetrics: N. J. Obstetrical and Gynecologic Society. (Dr. H. S. Murphy, 320 Chestnut St., Roselle.)
Orthopedics: N. J. Orthopedic Society. (Dr. R. R. Goldenberg, 588 East 27th Street, Paterson 4.)
Pathology: See clinical pathology, above.
Pediatrics: N. J. Section, American Academy of Pediatrics. (Dr. H. A. Murray, 624 Mt. Prospect Avenue, Newark 4.)
Proctology: N. J. Proctologic Society. (Dr. F. S. Forte, 318 Roseville Avenue, Newark 7.)
Psychiatry: N. J. Neuropsychiatric Association Dr. D. J. Flicker, 82 Clinton Avenue, Newark 5.)

Radiology: The Radiological Society of New Jersey (Dr. W. H. Seward, 188 South Essex Avenue, Orange, N. J.)

Surgery: The Society of Surgeons of New Jersey. (Dr. W. B. Mount, 21 Plymouth Street, Montclair.)

Tuberculosis: N. J. Chapter, American College of Chest Physicians. (Dr. P. K. Bornstein, 320 Asbury Avenue, Asbury Park.)

Venereal Diseases: N. J. Association of Venereal Disease Physicians. (Dr. R. L. McKiernan, 97 Bayard Street, New Brunswick.)

GONOCOCCUS CULTURE STATIONS IN NEW JERSEY

Specimen tubes may be obtained at any of these stations and must be returned to the incubator at the station *within three hours* after the slant has been streaked. To obtain satisfactory results, the instructions accompanying each tube must be meticulously followed.

ALLENTOWN—Farmers Hospital.
ASBURY PARK—Bureau of Health.
ATLANTIC CITY—Atlantic City or Municipal Hospitals; Hunt Laboratory (805 Atlantic Avenue) or Kuland Pharmacy (118 Dewey Place).
BAYONNE—Bayonne Hospital.
BELLEVILLE—Department of Health (Town Hall).
BLOOMFIELD—Health Department.
BOUND BROOK—Bound Brook Hospital.
BRIDGETON—Bridgeton Hospital.
CAMDEN—Cooper or West Jersey Homeopathic Hospital.
CAPE MAY COURT HOUSE—The Court House Building.
CRANFORD—Hampton Laboratory (321 Casino Avenue).
DOVER—The Dover General Hospital; also at the District Health Office (16 West Blackwell St.)
EAST ORANGE—General Hospital; also at the City Health Department.
ELIZABETH—St. Elizabeth's Hospital; the Biochemical Laboratory (1137 East Jersey Street) or the City Health Department.
ENGLEWOOD—Englewood Hospital.
FAIR LAWN—Fair Lawn Clinical Laboratory (75 Midland Avenue).
FRANKLIN—Franklin Hospital.
FREEHOLD—Freehold Health Center (Lafayette Place).
HACKENSACK—District Health Office (Room 207 Administration Building).
HOBOKEN—St. Mary's Hospital.
IRVINGTON—Health Department.
JERSEY CITY—Christ Hospital; Hudson County Board of Health Laboratory; the Medical Center; Physicians and Surgeon Clinical Laboratory (591 Summit Ave.) and St. Francis Hospital.
KEARNY—West Hudson Hospital.
KEYPORT—Health Department.
LAKEWOOD—Paul Kimball Hospital.
LINDEN—Health Department, City Hall.
LONG BRANCH—Board of Health (City Hall) and also the Monmouth Memorial Hospital.
MAY'S LANDING—District Regional Health Office.
MILLVILLE—Millville Hospital.
MONTCLAIR—Health Department (65 Chestnut St.); the Mountainside Hospital and the Montclair Community Hospital.
MORRISTOWN—All Soul's Hospital and the Morristown Memorial Hospital.
MOUNT HOLLY—Burlington County Hospital.
NEPTUNE—Fitkin Memorial Hospital; also the Township Board of Health.
NEWARK—Any of the following hospitals: American Legion, eth Israel, Babies, City, Columbus, Community, Lutheran Memorial Presbyterian, St. Barnabas, St. James or St. Michaels; also at the Clinical Laboratory (31 Lincoln Park).
NEW BRUNSWICK—Middlesex General or St. Peter's Hospital.
NEW MONMOUTH—Middletown Health Center.
NEWTON—Memorial Hospital.
NORTH ARLINGTON—Health Department.
NUTLEY—Health Department.
OCEAN CITY—Friel Laboratory (332 Asbury Avenue).
ORANGE—Memorial Hospital or St. Mary's Hospital.
PASSAIC—General Hospital, St. Mary's Hospital, Beth Israel Hospital, Laboratory Service (199 Monroe St.) or Clinical Laboratory (20 Grove Street).
PERTH AMBOY—General Hospital; or the Laboratory at 138 Market St.
PHILLIPSBURG—Warren Hospital.
PRINCETON—Health Department or Princeton Hospital.
RAHWAY—Rahway Hospital.
RED BANK—Riverview Hospital; or either of the Clinical Laboratories at 157 Broad Street (room 28) or 71 East Front Street.
RIVERSIDE—Zurbrugg Hospital.
ROSELLE—Board of Health.
SALEM—County Memorial Hospital.
SECAUCUS—Hudson County Hospital for Contagious Diseases.
SOMERS POINT—Shore Memorial Hospital.
SOMERVILLE—Somerset Hospital.
SUMMIT—Overlook Hospital, the Summit Medical Group (129 Summit Ave.) or the Health Department (71 Summit Ave.).
SUSSEX—Alexander Linn Hospital.
TOMS RIVER—Ocean County Health Department.
TRENTON—Mercer, McKinley or St. Francis Hospitals.
UNION CITY—Board of Health (Town Hall) or Diagnostic Laboratory at 408 Thirty-Sixth Street.
VINELAND—Newcomb Hospital.
WEEHAWKEN—North Hudson Hospital.
WESTFIELD—The Board of Health; also the Clinipath Laboratories in the Rialto Building.
WEST NEW YORK—General Research Laboratory.
WOODBURY—Underwood Hospital.

GRADUATE EDUCATION FOR PHYSICIAN-VETERANS

Courses for graduate education of physicians are sponsored by both The Medical Society of New Jersey and by the Essex County Medical Society. Such courses are open to all physicians in the state. For details, schedules, and other information write to "Committee on Postgraduate Medical Education" at The Medical Society of New Jersey (315 West State Street, Trenton 8) or to the committee at the Essex County Medical Society (91 Lincoln Park, Newark 5).

Physician-veterans may, under conditions explained below, take advantage of Public Law 346 ("The G.I. Bill of Rights") which would make courses available without personal cost to the doctor.

Honorably discharged physician-veterans of World War II are eligible for educational benefits for a period of time equal to one year plus duration of their active duty since September 16, 1940, and prior to the termination of the war, not including time spent on active duty in A.S.T.P. or Navy V-12 programs. In no case may the period of education exceed four years.

Certain benefits of the law relating to education and to loans are available to veteran officers while on terminal leave. The institution in which such a veteran undergoes training can be paid tuition fees during that period but the veteran will not be entitled to subsistence until after his discharge. However, allowances for books, laboratory fees, and so forth, will be extended as soon as educational requirements are met, even though the schooling starts prior to final discharge.

HOW TO DO IT

It is necessary for the veteran to establish his eligibility by filing application form 1950. A certified copy of his discharge (or photostatic copy) should accompany the application. In return, the veteran physician receives a Certificate of Entitlement which must be submitted to the approved hospital for endorsement. Benefits cannot be paid until the Certificate of Entitlement is turned over to the approved hospital or training institution.

Short Intensive Training Courses of Less than Thirty Weeks: Institutions providing refresher courses of less than thirty weeks, having regular established fees, must be approved by the appropriate state agency and must arrange for tuition payments with the Regional Office of the Veterans Administration. For refresher courses there will be charged against the veterans time period of eligibility the proportion of an ordinary school year which the cost of the course bears to $500. For example, if an eligible veteran elects a two-month refresher course for which $250 is paid, there will be charged against the veteran's period of eligibility for training, not two months, but a half of the ordinary school year, since $250 is one-half of $500.

SUBSISTENCE ALLOWANCE

The subsistence allowance for a veteran without dependents is $65 per month and for a veteran with dependents $90 per month. The total, however, of the subsistence allowance plus the stipend or other wages the doctor receives from the hospital may not be more than $175 per month in the case of a veteran without dependents, or $200 for a veteran with dependents, if the total subsistence is to be paid.

RESIDENCIES

Instruction furnished to the physician-veteran should be regarded as institutional training. This applies to all acceptable residency hospitals, whether or not they are affiliated with a medical school. Qualified physician-veterans pursuing training in connection with residencies or fellowships are eligible for subsistence benefits and approved hospitals are eligible to apply for tuition remuneration.

Although the Veterans Administration has established the general principle that hospitals conducting acceptable residencies are eligible for participation under the bill, it is still necessary for each residency hospital to seek approval as an individual institution from the appropriate state agency.

It is advisable for each physician to check personally on the approval for residencies and refresher courses at the hospital or institution where he intends to register.

G. I. LOANS

The loan provisions of the bill can assist the veteran-physician in securing a home or in purchasing an existing practice. All details of the transaction may be handled through a local lending agency, most of whom are now familiar with the loan guarantee privilege. Briefly, this entitles the doctor to have the government guarantee a portion of his loan from the bank. The government will guarantee home loans up to 50 per cent of the loan, or $4,000, whichever is the lesser amount, and 50 per cent of the loan up to $2,000 for business purposes. Interest on the guaranteed portion of the loan is paid by the government during the first year.

THE 1947 STATE LEGISLATURE

THE SENATE

COUNTY	NAME	P. O. ADDRESS
Atlantic	Frank S. Farley	Atlantic City
Bergen	David VanAlstyne, Jr.	Englewood
Burlington	Arthur W. Lowis	Riverton
Camden	John L. Morrissey	Camden
Cape May	George A. Redding	N. Wildwood
Cumberland	Elmer H. Wene	Vineland
Essex	Roy V. Wright	East Orange
Gloucester	Harold W. Hannold	Westville
Hudson	Edward J. O'Mara	Jersey City
Hunterdon	Samuel L. Bodine	Flemington
Mercer	C. Wesley Armstrong, Jr.	Trenton
Middlesex	John E. Toolan	Perth Amboy
Monmouth	Haydn Proctor	Asbury Park
Morris	David Young, III	Towaco
Ocean	W. Steelman Mathis	Toms River
Passaic	Charles K. Barton	Paterson
Salem	John M. Summerill, Jr.	Penns Grove
Somerset	H. Rivington Pyne	Bedminster
Sussex	Alfred B. Littell	Franklin
Union	Herbert J. Pascoe	Elizabeth
Warren	Harry Runyon	Belvidere

THE GENERAL ASSEMBLY

COUNTY	NAME	P. O. ADDRESS
Atlantic	Leon Leonard	Atlantic City
	Richard S. Mischlich	Egg Harbor City
Bergen	Walter H. Jones	Hackensack
	William B. Widnall	Saddle River
	Lawrence A. Cavinato	Fort Lee
	William R. Morrison	Ridgefield P.
	Lillian A. Mathis	Hackensack
	Robert H. Pike	Teaneck
Burlington	Albert McCay	Palmyra
Camden	William E. Peel	Camden
	Emory S. Kates	Westmont
	R. Cooper Brown	Collingswood
Cape May	Nathaniel C. Smith	Ocean City
Cumberland	Robert G. Howell	Bridgeton
Essex	Minna P. Greenbaum	Newark
	Stephen J. Bator	Maplewood
	Elwood P. Russell	Belleville
	Grace M. Freeman	East Orange
	Lewis M. Herrmann	Newark
	William M. Litvany	Bloomfield
	Percy A. Miller	Irvington
	James H. Sanderson	East Orange
	Alfred P. Harris	Verona
	James O. Hill	Newark
	Frank Cozzoline	Newark
	Cyrus H. Loutrel	Newark
Gloucester	Hugh L. Meherter	Woodbury
Hudson	Peter P. Artaserse	Jersey City
	Charles C. Jones	Bayonne
	Jacob Friedland	Jersey City
	John J. Grogan	Hoboken
	E. M. V. Urbanski-Courtney	Jer. City
	William V. Musto	Union City
	George B. Schaeffer	Secaucus
	John J. Manley	Kearny
	T. James Tumulty	Jersey City
Hunterdon	Emmert R. Wilson	Stockton
Mercer	Howard S. Keim	Trenton
	Albert F. Clemens	Trenton
	C. Stanley Stults	Hightstown
Middlesex	William H. Dickson	Metuchen
	Bernard W. Vogel	Woodbridge
	John J. Brixie	Perth Amboy
Monmouth	J. Stanley Herbert	Sea Girt
	Merrill H. Thompson	Interlaken
Morris	Norman J. Griffiths	Madison
	Thomas J. Hillery	Boonton
Ocean	Lettie E. Savage	Lakewood
Passaic	Mattie S. Doremus	Paterson
	Reuben H. Reiffin	West Paterson
	Frank W. Shershin	Clifton
	Peter P. Zangara	Passaic
Salem	Peter B. Hoff	Salem
Somerset	Freas L. Hess	Somerville
Sussex	Amos F. Dixon	Stillwater
Union	Joseph Louis Brescher	Elizabeth
	Charles R. Geddes	Union
	G. Clifford Thomas	Elizabeth
	Thomas M. Muir	Plainfield
Warren	Harold A. Searles	Belvidere

SENATE COMMITTEES CONCERNED WITH HEALTH AND RELATED MATTERS

Alcoholic Beverages: Senators Farley, Lewis, Young O'Mara

Aviation: Senators Hannold, Proctor, Mathis and Runyon

Education: Senators Pynes, Pascoe Armstrong and Toolan

Health: Senators Redding, Armstrong, Van Alstyne and Morrissey

Institutions and Agencies: Senators Armstrong, Hannold, Pyne and Runyon

Social Welfare: Senators Lewis, Armstrong, Van Alstyne and Wene

Veterans: Senators Littell, Bodine, Young and Morrissey

Water Supply: Senators Pyne, Young, Redding and Toolan

ASSEMBLY COMMITTEES CONCERNED WITH HEALTH AND RELATED MATTERS

Alcoholic Beverages: Assemblymen Reiffen, Litvany, Howell, Herbert and Artaserso

Civil Service: Assemblymen Zangara, Greenbaum, Pool, Hillery and Musto

Education: Assemblymen Freeman, Dixon, Geddes, Clemens and Tumulty

Health: Assmblymen Hill, Savage, Geddes, Clemens and Brixie

Institutions and Agencies: Assemblymen Greenbaum, Mthis, Griffiths, Geddes nd Courtney.

Social Welfare: Assemblymen Cozzoline, Shershin, Mathis, Searles, and Friedland

Unemployment Compensation: Assemblymen Miller, Hess, Griffiths, Geddes and Grogan

Veterans: Assemblymen Thomas, Cavinato, Hoff, Brown and Vogel

Water Supply: Assemblymen Hillery, Pike, Shershin, Harris and Manley

NARCOTIC REGULATIONS

Under the provisions of the Federal narcotic law and regulations, a physician must register and pay a special tax of one dollar in order legally to prescribe, administer and dispense narcotic drugs. The term "narcotic drugs" under the Federal law means opium, coca leaves and isonipecaine and all salts, derivatives and preparations of opium, coca leaves and isonipecaine. To be entitled to register under the Federal law, a physician must be qualified in the state where he resides to practice his profession and to use narcotic drugs in such practice. Registration and payment of the special tax must be made annually on or before July 1. Isonipecaine above referred to is the scientific name for the synthetic drug known as demerol, which possesses addiction sustaining and habit-forming properties.

WHEN NARCOTICS MAY BE PRESCRIBED

A physician may prescribe, dispense and administer narcotic drugs only in the course of his professional practice and for legitimate medical needs. The prescribing, dispensing and administering of narcotic drugs to an addict solely for the purpose of satisfying the addict's craving for the drug is not considered to be for legitimate medical needs.

OFFICE SUPPLIES OF NARCOTICS

In obtaining a supply of narcotic drugs for office use, a physician should use the official order forms which may be obtained from the Collector of Internal Revenue for the district. Do not use ordinary prescription blanks to procure narcotics for your own office. Write to the Collector of Internal Revenue, Narcotics Division, Post Office Building, Newark 2, N. J., for the special order forms and for further explanations.

THE NARCOTIC PRESCRIPTION

A prescription may be used to supply an individual patient with a quantity of narcotic drugs. To be lawfully executed, a prescription should contain the name and address of the patient, the signature and registry number of the physician, the kind and quantity of narcotic drug and it must be dated as of the day it is issued. It should be written with ink, indelible pencil or typewriter. The signature, however, must be written in the physician's own hand. Furthermore, the prescription must be written in the course of professional practice and for legitimate medical needs only. It is unlawful for a druggist to sell narcotic drugs without first obtaining a written prescription. Therefore, a physician should not expect a pharmacist to fill a telephonic prescription for narcotics. (A "telephonic prescription" is a contradiction anyway: there is no such thing). In cases of extreme urgency, a physician may telephone an order to the druggist, provided a written prescription is available *to be handed to the pharmacist or his messenger when the drugs are delivered.* If the Rx is not there the druggist is quite right in refusing to deliver the narcotic.

THE DOCTOR'S RECORDS

A duplicate copy of all order forms used by a physician must be retained by him for a period of at least two years. He must also keep a record of all narcotic drugs dispensed, showing the date, the quantity and kind of drug and the name and address to whom dispensed. Each year prior to renewing his registration a physician is required to make an inventory of the narcotic drugs which he has on hand. The original is submitted to the Collector of Internal Revenue at the time application is made for re-registration. The duplicate copy of the inventory should be retained by the physician for a period of two years. The narcotic records of a physician are subject to inspection by a Federal narcotic agent at any time. One of the chief reasons for these record keeping requirements is to enable the Federal Government to check on the flow

and distribution of narcotic drugs which is required of the Government in fulfilling certain treaty obligations. In addition, it enables the Government officers to apprehend non-medical addicts who will use every subterfuge imaginable to obtain narcotic drugs.

WHEN YOU MOVE

The narcotic tax stamp is issued to you at a specified address. If you move your office, notify the Collector of Internal Revenue at once, so that an amended stamp may be issued. A registration entitling you, at 25 Main Street, to write narcotic prescriptions, does not cover you if your principal office is 50 Jones street. Don't move your office without informing the Collector.

A WORD TO THE WISE

It is always embarrassing to have a forged narcotic prescription turn up on one of your own Rx blanks. And it is always embarrassing to explain how your office drug supply was rifled. It is, therefore, pertinent to suggest that physicians keep their blank prescriptions out of sight, and not where they may be easily picked up. Also, there has been an increase in the number of thefts of doctor's bags from parked automobiles. To eliminate this source of drugs to the illicit traffic, it is suggested that physicians carry their bags with them rather than leave them in their cars.

PHYSICIAN-POPULATION-HOSPITAL RATIOS IN NEW JERSEY

The general ratio of population to physicians in the U. S. A. is 752. That is, there is one medical practitioner for every 752 persons. In New Jersey, the ratio is 835. Within the state, however, there are wide fluctuations from a low of 621 in Essex County (which is, therefore, the best supplied county in the state) to a high of 1281 in Salem County. Even more striking variations are found in the ratio of general hospital beds to the population. Using as an index the number of general hospital beds to each ten thousand persons, the best ratio is in Ocean county: 50 beds. The counties of Cape May and Hunterdon have no approved general hospitals, so the ratio there is zero. The state figure is 33 general hospital beds per ten thousand persons.

County	Population	Physicians	Population Per M.D.	Beds in General Hospitals	General Hospital Beds Per 10,000
Atlantic	124,006	168	732	325	27
Bergen	409,646	422	971	631	15
Burlington	97,013	81	1,200	168	17
Camden	255,727	239	1,070	893	36
Cape May	28,919	42	690	....	..
Cumberland	73,814	71	1,040	230	33
Essex	837,340	1,347	621	3,488	42
Gloucester	72,219	62	1,165	65	9
Hudson	652,040	646	1,009	2,670	40
Hunterdon	36,766	35	1,050	....	..
Mercer	197,318	239	825	917	45
Middlesex	217,077	202	1,075	492	22
Monmouth	161,238	199	810	579	35
Morris	125,732	149	844	371	29
Ocean	37,760	43	878	198	50
Passaic	309,353	417	742	1,382	44
Salem	42,274	33	1,281	40	10
Somerset	74,390	82	907	130	18
Sussex	29,632	32	926	102	34
Union	328,344	430	763	837	26
Warren	50,181	42	1,194	65	13
STATE OF N. J.	4,160,165	4,981	835	12,628	33

NOTES: "Physicians" indicates doctors in private practice only. "General hospitals" excludes mental, isolation, tuberculous, army and navy institutions.

SURVIVORS INSURANCE

Physicians in attendance at deaths are often in a position to remind the widow or dependent children that there may be a survivors' benefit payable under social security legislation. The government is anxious to pay all such claims but cannot pay them unless application is made. Many widows do not realize that they are entitled to benefits under the law. One reason is a confusion between unemployment compensation and survivors' insurance. To set the record straight, the following tabulation has been prepared by the local office of the Social Security Board:

The misunderstanding is due chiefly to the basic similarities of the program; both are part of the same "family security" since both promote the "social security" of workers and their families. The following list shows the essential differences between the two insurances in New Jersey:

	FEDERAL OLD-AGE AND SURVIVORS INSURANCE	NEW JERSEY STATE UNEMPLOYMENT COMPENSATION
PURPOSE	To protect workers and their families against loss of income because of old-age or death of the worker.	To protect workers against loss of income because of unemployment.
COVERAGE	Workers for employers who have one or more employees at any time in stores, offices, factories, industrial or commercial jobs.	In general, workers in the kinds of jobs covered by the OASI program, except that the employer must have had four or more employees in at least 20 weeks during the year.
BENEFITS	Benefits are paid monthly and are of two major kinds: (1) RETIREMENT BENEFITS for the insured worker himself after he reaches 65; his wife when she is 65; his children until they are 16 or 18 if still in school. (2)SURVIVORS PAYMENTS WHEN AN INSURED WORKER DIES, for his widow and their children under 16 or 18, if still in school, his widow when she reaches 65, his dependent parents at age 65 if he has left no widow or young child. In some cases a lump sum is payable.	Benefits are paid to workers who have lost their jobs or who are partly unemployed through no fault of their own, if they have had sufficient previous earnings, provided they meet the requirements of the State law. They must be able and available for work, and benefits are not paid if unemployment is due to illness. See page 148 of the April 1946 issue of the *Journal of the Medical Society of New Jersey*.
AMOUNT OF BENEFITS	Size of payments depend on worker's average monthly wage. The minimum benefit is $10 and maximum is $85 per month. Benefits are payable as long as conditions of the law continue to be met and not for any specified number of months or years.	Size of payment depend upon the amount of wages the worker had earned on covered jobs. The minimum benefit is $9 per payment, and the maximum is $22. The maximum number of payments is 26 in a benefit year.
HOW BENEFITS ARE PAID FOR	Both workers and employers share the cost. The employer takes 1 cent from each dollar of a worker's pay, adds an equal amount and sends the total to the Federal Government. Only the first $3,000 of a worker's wages with each employer are taxable.	Employers and workers pay taxes on the first $3,000 of a worker's wages. Workers pay 1% of their wages and employers pay at a rate determined by the New Jersey Unemployment Compensation Commission on the basis of their benefit experience. It varies from 0.9% to 3.6% of wages paid.
APPLICATION FOR BENEFITS	Application should be made in person or by mail at the field office of the Social Security Board . Look in the telephone book under Federal Security Agency, Social Security Board.	Benefits must be claimed by the unemployed worker at a local office of the New Jersey Employment Service. At the same time he must also apply for work.

The following do *not* come under these insurances: farm workers, government employees, domestics, employees of certain nonprofit agencies and self-employed persons. (The latter includes most private medical practitioners who, being self-employed, are not covered.)

For further information apply to Social Security Board, Post Office Building, Trenton 9; or to Federal Security Agency, 45 Branford Place, Newark 2.

COMMITMENT PROCEDURE IN NEW JERSEY

Three types of neuropsychiatric disorders are certifiable for commitment to state and county institutions. These are (a) The psychoses, (b) mental deficiency, and (c) epilepsy. The law does not contemplate the commitment of alcoholics, drug addicts, neurotics, or psychopaths unless such a person also has a psychosis, epilepsy or mental deficiency.

The Psychoses

A patient who feels that he is becoming mentally disturbed may voluntarily enter a state or county mental hospital. This is effected through so-called "Voluntary Admission Papers", also known as a "Class D Commitment". The patient himself must sign the application. The paper also contains space in which the family physician may fill out pertinent data. If a patient goes to an institution voluntarily, he may leave at his own request by giving ten days notice. If he is suicidal or homicidal, the institutional authorities usually obtain a regular commitment during the ten-day waiting period. Blanks for voluntary admission papers are available in most general hospitals and may be obtained at the county adjuster's office or county attorney's office in the court house. The institutions to which a patient may be voluntarily certified are the same as those received patients by commitment—see next paragraph.

FORMAL COMMITMENT

A psychotic patient who needs institutional care and who will not, or should not, sign his own admission, is sent to the hospital on commitment papers. These papers, printed in eight-by-ten booklets are available in most general hospitals, police stations, social agencies, and court houses. The paper consists, in essence, of four sections: (1) An application to be signed by the patient's relative; (2) a medical certificate to be signed by a physician; (3) another medical certificate to be signed by another physician, and (4) a court order.

The Application is preferably signed by the nearest relative, but it may be signed by the sheriff, overseer of the poor, executive officer of the hospital where the patient may be, or by a high ranking police officer. At the end of the application (first section of the paper) is a form for affidavit. This should be executed by a notary public.

The Medical Certificate. To be eligible to sign a medical certificate on a commitment paper, the physician must meet these qualifications: (a) He must have been a New Jersey licensed practitioner for at least five years; (b) He must not be related (by blood or marriage) to the patient; (c) He must not be on the payroll of the institution to which it is proposed to send the patient; (d) He must have personally examined the patient on the date indicated. The certificate should be filled out with meticulous care, since it becomes a permanent legal document in affidavit form. Every question should be answered; an unfilled blank space might later be a source of embarrassment. The heart of the certificate is the question "The patient said—" and later "The patient did—". Insert a verbatim transcript of what the patient said that suggested psychosis. If he said nothing at all, the physician may write "remained persistently mute". In the section "the patient did—", the doctor should indicate the appearance, manner, activities, tidiness, and behavior of the patient. Do not write "the patient was hallucinating" or "disoriented" or "delusional" without listing what the patient said or did to indicate these disorders. A phrase such as "behaved strangely" is not enough to justify commitment and should not be used on a commitment paper. At the end of the medical certificate is space for an affidavit which should be executed by a notary public or attorney-at-law. The doctor must sign this affidavit in presence of the officer who notarizes it. The papers are good for ten days after the earliest date on any of the affidavits and if the patient is not actually in the hospital by then, the certificates expire.

To What Hospitals? Six counties have their own mental hospitals, and patients who have lived in the county for the required time (usually five years) are eligible for commitment to these institutions. The county mental hospitals in New Jersey are:

Atlantic County Hospital for Mental Diseases, at Northfield, N. J.

Burlington County Hospital for the Insane at New Lisbon, N. J.

Camden County Hospital for Mental Diseases at Lakeland (Blackwood, P. O. N. J.)

Cumberland County Mental Hospital at Bridgeton, N. J.

Essex County Hospital at Overbrook, Cedar Grove, N. J.

Hudson County Hospital for Mental Diseases at Secaucus.

Persons living in other counties, or not eligible for one of the above institutions may be sent to one of the three state hospitals. These are located as follows:

(a) At Greystone Park, N. J., (near Morristown)
(b) At Trenton, N. J., (Postal Zone, Trenton 8)
(c) At Marlboro, N. J., (near Freehold)

The counties from which these three hospitals receive are:

Greystone Park — Bergen, Essex, Hudson, Morris, Passaic and Sussex counties.

Marlboro—Middlesex, Monmouth, Ocean and Union counties.

Trenton—Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Salem, Hunterdon, Somerset and Warren counties.

Classes of Commitment—Legally there are five classes of commitment, designated by the letters A to E. Class D is the voluntary admission described above, and Class E is a commitment used for inmates of penal institutions. Physicians thus are concerned chiefly with classes A, B and C. A Class A commitment is made by a court after a special hearing, and cannot be used, therefore, when speed is necessary. If prompt institutional placement is required, the family should bring the papers (fully signed) to a Judge of a Circuit Court, Juvenile Court, or Common Pleas Court, and obtain his signature in the last section of the form. If the case is so urgent that even this procedure is not practical, this fact is stated on the application blank (there is a space for this just above the line for the applicant's signature) and it becomes a class C commitment which permits the family to bring the patient immediately to the hospital without a judicial order. In class C cases, the order is obtained later. If time permits, the physician should ask for a class A commitment whenever there is any resistance or dissatisfaction to the procedure on the part of any responsible relatives, since the class A procedures affords a hearing in open court and the doctor's good faith cannot be questioned.

Mental Deficiency

New Jersey has four institutions for the custody and training of mental defectives. Males are sent either to *New Lisbon* (which is in Burlington County) or to *Woodbine* (which is in Cape May County). Each of these institutions is called "N. J. State Colony for Feeble-Minded Males". For females, there is the North Jersey Training School at *Totowa* (Post Office Box 215, Little Falls, N. J., Passaic County) and the State School at *Vineland** (which is in Cumberland County). Physicians do not, however, commit a patient directly to the institution. Each has a long waiting list, and when papers are filled out and authenticated, the child's name is placed on the list to await a vacancy. In the meantime the State Department of Institutions and Agencies investigates and determines the appropriate institution.

Commitment papers for mental hospitals cannot and must not be used for mental defectives. Special New-Lisbon, Vineland, Totowa or Vineland certificates are secured at the court house. The papers consists of three parts: (a) An application, usually signed by the nearest relative of the patient, (b) and (c) certificates signed by two physicians. The court order is issued as a separate document. Only a physician may sign the medical certificate in New Jersey, though the actual psychometric testing is often done by a psychologist. To sign the paper, the physician must meet four requirements. He must (a) have been licensed to practice medicine in New Jersey for at least five years, (b) bear no relationship, by blood or marriage to the patient, (c) have no financial connection with the institution to which the patient is to be sent, and (d) must have personally examined the patient on the date indicated. When the papers are properly filled in, the doctor or the family should communicate with the Commissioner, Department of Institutions and Agencies, 135 West Hanover Street, Trenton 7.

Epilepsy

Epileptics who need institutional care may be sent to the N. J. State Village which is located at Skillman, near Trenton. Patients who are both epileptic and psychotic should be sent to a state hospital or to a county mental hospital (see Psychoses, above) rather than to Skillman. A patient who is both epileptic and mentally defective may be sent to Skillman. The minimum admission age for Skillman is five years. A special Skillman commitment paper is required (the forms for state hospitals and state colonies cannot be used) and may be obtained at the Court House. The procedure in filling out the commitment and filing it is substantially the same as that outlined above under "mental deficiency". When the papers are properly filled in, the family should communicate with the State Department of Institutions and Agencies for further instructions.

* Not to be confused with The Training School, a private institution, also located in Vineland, N. J.

THE NEW JERSEY MEDICAL PRACTICE ACT

The Medical Practice Act is cited as chapter 9 of the Laws of 1945. The Act is divided into sections, each of which is designated 45:9- followed by the section number.

45:9-1 describes the appointment of the State Board of Medical Examiners. After providing for the continuation of the Board as it existed at the time of the adoption of the law, this section goes on as follows:

The board shall consist of eleven members, who shall be persons of recognized ability and honor, and who shall be appointed by the governor from a list to be furnished within thirty days after any vacancy occurs in the membership of said board *by the society or organization of whom the persons nominated are members,* if there be such a society or organization, or if such society or organization has a membership in good standing of not less than one hundred, and for every membership filled in said board at least three names shall be submitted to the governor, and from the names thus submitted the governor shall select one person to be a member of said board; provided, however, that the said board shall consist of nine graduates of schools of medicine who shall possess the degree of M.D., of whom five shall be old school physicians, three shall be homeopaths, and one an eclectic, and in addition the membership of said board shall comprise one osteopath and one chiropractor. The term of office of members of the board hereafter appointed shall be three years or until their successors are appointed.

45:9-2 to 45:9-5 cover the organization of the Board, the appointment and compensation of inspectors, and the administrative details of the activities of the Board. The requirements for admission to examination are taken up in the next sections as follows:

45:9-6. License required to practice medicine or surgery; applications; educational requirements of applicants. All persons commencing the practice of medicine or surgery in this state shall apply to the board for a license so to do. The board shall, except as herein otherwise provided, examine all qualified applicants for such a license. Every applicant shall present to the secretary of the board, at least twenty days before the commencement of the examination at which he desires to be examined, a written application for admission to the examination on a form provided by the board, together with satisfactory proof that he is more than twenty-one years of age, of good moral character, and a citizen of the United States. He shall also present to the board a certificate of the commissioner of education of this state showing that, before entering a professional school or college, he had obtained an academic education consisting of a four years' course of study in an approved public or private high school or the equivalent thereof.

PREMEDICAL EDUCATION

45:9-7. Additional educational requirements. Except as otherwise provided in this chapter (45:9-1 et seq.), every applicant for admission to examination for a license to practice medicine and surgery shall also present to the board a certificate from the commissioner of education of this state showing that in addition to, and subsequent to, obtaining the preliminary education specified in section 45:9-6 of this title, and prior to commencing his study in a professional school or college, he had completed a satisfactory course in a college or school of arts and science approved by said commissioner, the duration of such course to have been one year if he matriculated in a professional school or college after July first, one thousand nine hundred and sixteen, and not later than July first, one thousand nine hundred and seventeen, and two years if he matriculated in a professional school or college after said July first, one thousand nine hundred and seventeen, during which year, or two years, as the case may be, he had studied either French, German, Italian or Spanish and also chemistry, physics and biology; but the board may, in its discretion, admit to examination for a license to practice medicine and surgery any person not meeting the educational requirements of this section, who by reason of having been engaged in the naval or military service of the United States was unable to appear before the board for examination prior to July first, one thousand nine hundred and nineteen. The additional requirements provided for this section shall not obtain with respect to any applicant who matriculated in a professional school or college prior to July first, one thousand nine hundred and sixteen.

MEDICAL SCHOOL AND INTERNSHIP

45:9-18. Requirement of medical or professional college diploma; service as hospital intern. Except as otherwise provided in this chapter (45:9-1) et seq.), every applicant for admission to examination for a license to practice medicine and surgery shall, in addition to the requirements set forth in sections 45:9-6 and 45:9-7 of this title, prove to the board that he has received a diploma from some legally incorporated professional school or college of the United States, which school or college, in the opinion of the board, was in good standing at the time of the issuance of the diploma, or a diploma or license conferring the full right to practice all of the branches of medicine and surgery in some foreign country, or if the said foreign country is engaged in war at any time during the next three years and the said applicant before June thirtieth, one thousand nine hundred and forty-four, satisfactorily proves to the board that he has been a resident of the State of New Jersey for the past ten years, he shall present a diploma from a professional school or college which in the opinion of the board was in good standing at the time of the issuance of the diploma, and shall further prove that, prior to the receipt of such diploma from any such professional school or college of the United States, or such diploma or license, as aforesaid, he had studied

not less than four full school years, including four satisfactory courses of lectures of at least eight months each, consecutively or in four different calendar years, in some legally incorporated and registered American or foreign professional school or schools, college or colleges in good standing in the opinion of the board, which courses shall have included a thorough and satisfactory course of instruction in medicine and surgery; and such applicant, if he has graduated from a professional school or college after July first, one thousand nine hundred and sixteen; shall further prove to the board, that after receiving such diploma or license, he has completed an internship acceptable to the board for at least one year in a hospital approved by the board, or in lieu thereof he has completed one year of post-graduate work acceptable to the board in a school or hospital approved by the Board. Any applicant who after July first, one thousand nine hundred and thirty-nine, commences the service of an internship in a hospital situate in this state, or in lieu thereof enters upon a course of post-graduate study, as hereinbefore provided, shall, before commencing such internship or course of post-graduate study, apply to the board on a form or forms provided by the board for a certificate which shall certify said applicant has qualified to commence said internship or for permission to attend courses of study in post-graduate work in lieu of internship, as the case may be. The certificate required by this section shall be presented by any such applicant to the board when he applies for admission to examination for a license to practice medicine and surgery.

45:9-9 covers requirements for candidates who were graduated from medical school prior to 1903, and *45:9-10* applies to those who were graduated before 1894. Section *45:9-11* permits practitioners who entered medical school before 1912 to waive certain premedical requirements.

EXAMINATION PROCEDURE

45:9-12. Examination fee; re-examinations; marking of papers for identification. The fee for all examinations provided for by this chapter (45:9-1 et seq.) shall accompany every application and shall be as follows: for the first or initial examination twenty-five dollars and for every re-examination twenty-five dollars. Upon the approval of the application for examination, such applicant shall thereupon be entitled to admission to such examination. If said applicant fails to pass the examination, he may be re-examined at the next regular examination. Each applicant shall sign his name opposite a number in a book kept for that purpose by the secretary of the board and shall mark his examination paper with said number, and shall be known to the members of the board only by such number until his papers have been examined and marked.

RECIPROCITY

45:9-13. Licenses without examination for licenses of other states. Any applicant for a license to practice medicine and surgery, upon proving that he has been examined and licensed by the examining and licensing board of another state of the United States or by the national board of medical examiners, may, in the discretion of the board of medical examiners of this state, be granted a license to practice medicine and surgery without further examination upon payment to the treasurer of the board of a license fee of one hundred dollars; provided, such applicant shall furnish proof that he can fulfill the requirements demanded in the other sections of this article relating to applicants for admission by examination. In any such application for a license without examination, all questions of academic requirements of other states shall be determined by the commissioner of education of this state.

NONCITIZENS

45:9-14. Temporary licenses for noncitizens. Any applicant who shall have been examined and licensed in accordance with the provisions of this chapter, who, when admitted to the licensing examination or when granted a license without examination, was a citizen of a foreign country and had declared his intention of becoming a citizen of the United States and who shall have been issued a license or shall have become entitled to a license valid for six years from the date of such declaration of intention and who shall fail to furnish to the State Board of Medical examiners prior to the expiration of said six years evidence of his having actually become a citizen, shall have a further period of two years from the date of expiration of said six-year period within which to furnish to the State Board of Medical Examiners evidence of his having actually become a citizen. If the applicant fails to furnish to the State Board of Medical Examiners evidence of his having actually become a citizen within said extended two-year period, he shall be required to surrender his said license, which said license shall for such reason become invalid and automatically revoked and his registration shall be annulled; provided, however, that should the license of any applicant expire before the passage of this act, such license shall be reinstated immediately after the effective date of this act and such applicant shall also have a further period of two years from the date of such expiration within which to comply with the provisions of this section.

OSTEOPATHS

45:9-14.1 Application by osteopathic physicians; licensing to practice medicine and surgery. Until November first, one thousand nine hundred and forty-one, any person licensed to practice osteopathy in this state, and desiring to enter upon the practice of medicine and sur-

gery, shall make application to the board for a license to do so. Such applicant for examination shall present to the secretary of the board, at least twenty days before the commencement of the examination at which he is to be examined, a written application on a form or forms provided by said board, and a fee of twenty-five dollars, together with satisfactory proofs that the applicant has completed an internship acceptable to the board for a period of two years in an osteopathic or medical hospital approved by the board or has served in a manner acceptable to the board for a period of two years as a resident surgeon in an osteopathic or medical hospital approved by the board, or has completed a post-graduate course of two years acceptable to the board in a school or college of osteopathy or medicine approved by the board; provided, that any person duly registered or licensed to practice osteopathy in the state of New Jersey who presents satisfactory proof that he has had at least three years of practice in surgery acceptable to the board in a hospital approved by the board, shall be admitted by the board to examination as to his qualifications for the practice of medicine and surgery without being required to prove that he has had two years' experence as an intern or a resident surgeon or has completed a two years' post-graduate course in surgery. Such examinations shall consist of the subjects, pharmacology and therapeutics, and surgery, and shall consist of the same questions as are given to the medical candidates for license to practice medicine and surgery. The osteopathic applicant shall be admitted to the regular examination at the same time and place the regular examinations are held. To each applicant for a license to practice medicine and surgery receiving a grade of not less than seventy-five per centum, the board shall forthwith issue a license to practice medicine and surgery in this state. The records of the board and the license shall state that the applicant was licensed under the exemption contained in this section.

45:9-14.3. Osteopathy defined. Within the meaning of the provisions of section 45:9-14.4, the practice of osteopathy shall include the diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity, mental or physical condition; provided, however, that a license to practice osteopathy shall not permit the holder thereof to prescribe administer or dispense drugs for intenal use in the treatment of any human ailment, disease, pain, injury, deformity, mental or physical condition or to perform such surgical operations as require cutting.

45:9-14.4. Osteopathic licenses continued in force. Any person holding a valid license to practice osteopathy within this state shall be authorized to continue to practice osteopathy, as herein defined, pursuant to said license, as though the act under which said license had been issued had not been repealed.

CHIROPRACTORS

45:9-14.5. Chiropractic defined. Within the meaning of the provisions of sections 45:9-14.6, 45:9-14.7, 45:9-14.8 and 45:9-14.9 hereof, the practice of chiropractic is defined as follows: "The detecting and adjusting, by hand only, of vertebral subluxations."

45:9-14.6. Chiropractic licenses issued under the provisions of L. 1920, c 4, p. 15, continued in force. A person holding a valid license issued in due course by virtue of the provisions of an act entitled "An act to regulate the practice of chiropractic," approved March third, one thousand nine hundred and twenty (L. 1920, c. 4, p. 15), or any acts supplementary thereto or amendatory thereof, shall be authorized to continue to practice pursuant to said license.

The next few subsections deal with the licensing of chiropractors.

The Act then goes on to the conduct of the examinations:

EXAMINATION SUBJECTS

45:9-15. All examinations shall be in the English language and except as otherwise provided, the questions shall be such as can be answered in common by all schools of practice. Examinations shall be in: pharmacology, therapeutics, obstetrics, gynecology, diagnosis, including diseases of the skin, nose and throat, surgery, including anatomy and diseases of the eye, ear, and genito-urinary organs, physiology, chemistry, histology, pathology, bacteriology hygiene, medical jurisprudence and such other subjects as the Board may decide. If any applicant has completed a course of four full school years of study in and has been regularly graduated from a school of homeopathy or eclecticism, the member or members of the board of those schools, respectively, shall examine such applicant in the pharmacology and therapeutics of the school from which such applicant has been so graduated. All examinations shall be both scientific and practical, and of such sufficient severity to test the candidate's fitness to practice medicine and surgery. If the examination is satisfactory, the board shall issue a license entitling the applicant to practice medicine and surgery in this state. Said application and examination papers shall be retained in the files of the board for five years, and shall be prima facie evidence of all matters therein contained. All licenses shall be signed by the president and secretary of the board and attested by the seal. All licenses

granted under the exemptions contained in this chapter (45:9-1 et seq.) shall bear indication of the school of practice in which the licensee is limited by virtue of said license to practice.

REVOCATION OF LICENSE

45:9-16. Refusal or revocation of licenses. The board may refuse to grant or may suspend or revoke a license or the registration of a certificate or diploma to practice medicine and surgery filed in the office of any county clerk in this state under any act of the legislature, upon proof to the satisfaction of the board that the holder of such license (a) has been adjudicated insane, or (b) habitually uses drugs or intoxicants, or (c) has practiced criminal abortion, or been convicted of the crime of criminal abortion, or has been convicted of crime involving moral turpitude, or (d) has advertised fraudulently, (e) becomes employed by any physician, surgeon, homeopath, eclectic, osteopath, chiropractor, or doctor who advertises fraudulently, or (f) shall have presented to the board any diploma, license or certificate that shall have been illegally obtained or shall have been signed or issued unlawfully or under fraudulent representations, or obtains or shall have obtained a license to practice in this state through fraud of any kind, or (g) has been guilty of employing unlicensed persons to perform work which, under this chapter (45:9-1 et seq.) can legally be done only by persons licensed to practice medicine in this state, or (h) has been convicted of a violation of any federal or state law relating to narcotic drugs. Before any license, or registration of a certificate or diploma to practice medicine or surgery filed in the office of any county clerk of this state under any act of the legislature, shall be suspended or revoked, except in the case of convictions of criminal abortions or convictions of a crime involving moral turpitude or convictions or violations of any federal or state law relating to narcotic drugs, the accused person shall be furnished with a copy of the complaint and be given a hearing before said board in person or by attorney, and any person whose license shall be suspended or revoked in accordance with this section shall be deemed an unlicensed person during the period of such suspension or revocation, and as such shall be subject to the penalties hereinafter prescribed for persons who practice medicine and/or surgery, without first having obtained a license so to do. Any person whose license, or registration of a certificate or diploma to practice medicine and/or surgery filed in the office of any county clerk of this state under any act of the legislature, shall be suspended or revoked under the authority of this chapter (45:9-1 et seq.) may, in the discretion of the board, be relicensed at any time to practice without an examination, or have his registration of a certificate or diploma, as aforesaid, reinstated,on application being made to the board.

FILING OF LICENSE

45:9-17. Filing of license or copy thereof with county clerk. Any person receiving a license under the provisions of this article shall file it, or a certified copy thereof, with the clerk of the county in which he resides, and the clerk shall file the same and enter a memorandum thereof in a book to be approved by the board and to be kept for that purpose, giving the date of said license, the name and address of the licensee and the date of filing, for which registry said clerk shall be entitled to a fee of one dollar. If the licensee moves into another county, he shall procure from said clerk a certified copy of such registration and file the same with the clerk of the county to which he removes, who shall file and enter the same with like effect as if the same were an original license, and for which registry the clerk shall be entitled to a fee of one dollar. Upon each registry or reregistry, the registrant shall make an affidavit that he is the person described in the license or registration copy. Each county clerk shall, upon the last day of November of each year, furnish the secretary of the board a list of all licenses, and certified copies of licenses and registration of licenses of the board filed in his office during the previous year, together with any certified copies of registrations issued by him as above provided, and upon notice to him of the change of location or death of a licensee or of the revocation of a license, the clerk shall enter, at the appropriate place in the records so kept by him, a memorandum of the fact, which memorandum shall be furnished by said clerk to the secretary of the board in the annual report above required.

USE OF TITLE "DOCTOR"

45:9-18. Who regarded as practitioners. Any person shall be regarded as practicing medicine and surgery, within the meaning of this chapter, who shall use the words or letters "Dr.", "doctor", "professor", "M.D.", or "M.B." in connection with his name, or any other title intending to imply or designate him as a practitioner of medicine or surgery in any of its branches, and who, in connection with such title or titles, or without the use of such titles, or any of them, holds himself out as

being able to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity or physical condition, or who shall either offer or undertake by any means or methods to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition. The provisions of this chapter shall apply to all persons professing and attempting to cure disease by means of the so-called system of "faith-curism", "mind-healing", "laying-on-of-hands", and other similar systems.

RELIGIOUS HEALING

45:9-18.1. Provisions not applicable to practice of healing. This chapter shall not apply nor shall it in any manner be construed to apply to persons practicing healing by spiritual, religious or mental means if no material medicine is prescribed or used and no manipulation or material means are used.

REPORTS OF CONVICTIONS

45:9-19. Clerks of courts to report to board convictions of physicians. The clerk of every court wherein any person licensed to practice medicine and surgery in this state is convicted of a crime shall make a report thereof in writing to the board upon blanks provided by the board. The report shall state the name and address of the person so convicted, the date thereof, the nature of the crime of which he was convicted and the sentence imposed by the court.

45:9-20. Certificates of records of board as to issuance of licenses. The secretary of the board whenever requested so to do, shall certify over the seal of the board whether the records kept by the board show or fail to show the issuance of a license to practice medicine and surgery or any branch thereof, osteopathy, midwifery, chiropody or any other profession or business, the practice of which may be licensed by the board, or the issuance of any annual certificate of registration for such practice. The fee for such certificate shall be one dollar. Any such certificate, made on such request or made by such secretary for use in proceedings to which the board may be a party, shall be prima facie evidence of the facts therein stated.

EXEMPTIONS

45:9-21. Certain persons and practices excepted from operation of chapter. The prohibitory provisions of this chapter shall not apply to the following:

a. A commissioned surgeon or physician of the regular United States army, navy or marine service while so commissioned and actively engaged in the performance of his official duties. This exemption shall not apply to reserve officers of the United States army, navy or marine corps, or to any officer of the national guard of any state or of the United States;

b. A lawfully qualified physician or surgeon of another state taking charge temporarily, on written permission of the board, of the practice of a lawfully qualified physician or surgeon of this state during his absence from the state, upon written request to the board for permission so to do. Before such permission is granted by the board and before any person may enter upon such practice he must submit proof that he can fulfill the requirements demanded in the other sections of this article relating to applicants for admission by examination or indorsement from another state. Such permission may be granted for a period of not less than two weeks nor more than four months upon payment of a fee of twenty-five dollars ($25.00). The board in its discretion may extend such permission for further periods of two weeks to four months but not to exceed in the aggregate one year;

c. A physician or surgeon of another state of the United States and duly authorized under the laws thereof to practice medicine or surgery therein, if such practitioner does not open an office or place for the practice of his profession in this state;

d. A person while actually serving as a member of the resident medical staff of any legally incorporated charitable or municipal hospital or asylum aproved by the board. Hereafter such exemption of any resident physician shall not apply with respect to any individual after he shall have served as a resident physician for a total period of two years, and such exemption of resident physicians, except with respect to persons who shall have commenced service as resident physicians prior to July first, one thousand nine hundred and thirty-nine, shall apply only to persons who have been issued certificates under provisions contained in section 45:9-8 of this title;

e. The practice of dentistry by any legally qualified and registered dentist;

f. The ministration to, or treatment of, the sick or suffering by prayer or spiritual means, whether gratuitously or for compensation, and without the use of any drug or material remedy;

b. The practice of optometry by any legally qualified and registered optometrist;

h. The practice of chiropody by any legally licensed chiropodist;

i. The practice of pharmacy by a legally licensed and registered pharmacist of this state, but this exception shall not be extended to give to said licensed pharmacist the right and authority to carry on the business of a dispensary, unless the dispensary shall be in charge of a legally licensed and registered physician and surgeon of this state;

j. A person claiming the right to practice medicine and surgery in this state who has been practicing therein since before July fourth, one thousand eight hundred and ninety, if said right or title was obtained upon a duly registered diploma, of which the holder and applicant was the lawful possessor, issued by a legally chartered medical institution which, in the opinion of the board, was in good standing at the time the diploma was issued;

k. A professional nurse, or a graduate physiotherapist, masseur, electro-therapist, or hydrotherapist, while operating in each particular case under the specific direction of a regularly licensed

physician or surgeon. This exemption shall not apply to such assistants of persons who are licensed as osteopaths, chiropractors, optometrists or other practitioners holding limited licenses; or

l. A person while giving aid, assistance or relief in emergency or accident cases pending the arrival of a regularly licensed physician or surgeon or under the direction thereof.

ENFORCEMENT

45:9-22 outlines the procedure for enforcing the act and describes the penalties for illegal practice. "Any person . . . . who violates any of the provisions of this chapter shall be liable to a penalty of $200 for the first offense."

45:9-23 provides for the incarceration in the county jail for from ten to one hundred days of any person convicted under the act, who fails to pay the amount of the judgment.

45:9-24 and *45:9-25* outline further details of the legal processes involved.

45:9-26 provides a penalty of $500 for succeeding offenses, with a jail sentence of from thirty to two hundred days for persons convicted under this section who fail to pay the judgment. This section also validates trial without a jury: ". . . the trial thereof shall proceed in a summary manner without a jury".

The authorization for trial without jury of first offenders is found in section 45:9-23.

45:9-27 makes provision for the signing and sealing of the processes, the docketing of judgments, the issuance of execution and vests in the Court of Chancery the power to "prevent and restrain the practice of medicine by any person who has not first obtained and filed a license".

OFFICERS OF COUNTY MEDICAL SOCIETIES

AS OF MARCH 15, 1947

County	President	Secretary	Reporter
ATLANTIC	Lawrence A. Wilson, Absecon	Daniel C. Reyner, Atlantic City Tel. 4-1626	Anthony G. Merendino, Atl. City
BERGEN	Albert W. Cloud, Englewood	Edward V. Sexton, Teaneck Tel. 6-7740	H. E. Reinhold, West Englewood
BURLINGTON	William E. Bray, Pemberton	Howard C. Curtis, Moorestown Tel. 0646	T. Bruce Dickson, Riverton
CAMDEN	Henry B. Decker, Camden	Arthur G. Pratt, Camden Tel. 0004	Joseph C. Lovett, Camden
CAPE MAY	J. S. D. Eisenhower, Wildwood	Clarence W. Way, Sea Isle City Tel. 3-5521	Clarence W. Way, Sea Isle City
CUMBERLAND	Albert B. Kump, Bridgeton	F. Muriel Ramsey, Millville Tel. 31	Norman Henry, Vineland
ESSEX	Thomas W. Harvey, Jr., Orange	Marcus H. Greifinger, Newark Tel. Market 3-1918	Felix J. DiFino, Newark
GLOUCESTER	Isaac N. Patterson, Westville	Clarence A. Bowersox, Woodbury Tel. 100	A. Guy Campo, Westville
HUDSON	Claudio E. McNenney, Jersey City	Vincent P. Butler, Jersey City Tel. Delaware 3-7855	Harry J. Perlberg, Jersey City
HUNTERDON	Philip W. Baker, High Bridge	Edgar W. Lane, Bloomsbury Tel. Phillipsburg 10-R-13	E. W. Lane, Bloomsbury
MERCER	John L. Wikoff, Trenton	A. Dunbar Hutchinson, Trenton Tel. 3-5542	A. Dunbar Hutchinson, Trenton
MIDDLESEX	Frederick S. Taber, New Brunswick	Oscar J. Sokoloff, New Brunswick Tel. 2-5366	W. R. Greenwood, N. Brunsw'k
MONMOUTH	James P. Pregnall, Asbury Park	Elsworth F. Baker, Marlboro Tel. Freehold 1166	F. Lawton Hindle, Red Bank
MORRIS	Alden P. King, Dover	Stanley Teskey, Bernardsville Tel. 213	John S. Forbes, Jr., Basking Rdg.
OCEAN	Raymond A. Taylor, Lakewood	Norman F. Szold, Lakewood Tel. 1013	Harvey Rinzler, Toms River
PASSAIC	Harry Wolfson, Paterson	Irving Okin, Paterson Tel. Lambert 3-6686	Joseph E. Mott, Paterson
SALEM	William T. Hilliard, Salem	Harry F. Suter, Penns Grove Tel. 65	William H. Miller, Woodstown
SOMERSET	James L. Young, Somerville	Arthur F. Mangelsdorff, Bound Br'k Tel. 500	William F. Jones, Somerville
SUSSEX	Clifford M. Schmidt, Newton	James H. Spencer, Jr., Newton Tel. 605	Herbert M. Aitken, Ogdensburg
UNION	Elton W. Lance, Rahway	Frederic W. Lathrop, Elizabeth Tel. 3-0200	Edward G. Bourns, Westfield
WARREN	Harry B. Bossard, Phillipsburg	Paul F. Drake, Phillipsburg Tel. 5-3101	Philip B. Kassow, Alpha

OPPORTUNITIES FOR PHYSICIANS IN U.S.P.H.S.

Commissions are available to physicians in the U. S. Public Health Service, especially to those trained in bacteriology, psychiatry, parasitology and biochemistry. Vacancies in other specialties occur from time to time. Salaries are comparable to those paid to army and navy officers, including all allowances plus the other benefits of commissioned service. Disability retirement is at three-quarters pay. Periodic promotions and thirty days annual leave with pay are other features. The USPHS is the oldest federal medical service in the country and has an unblemished tradition of high scientific standards. Inquiries are directed to Surgeon General, United States Public Health Service, Washington 25, D. C.

OPPORTUNITIES FOR PHYSICIANS IN THE VETERANS ADMINISTRATION

Under Public Law 293, the Veterans Administration's Department of Medicine and Surgery has been completely reorganized and rejuvenated. Appointments are made directly by the VA without reference to the Civil Service Commission.

Physicians in the VA are classed in six grades with pay as follows:

Chief Grade. Must be Board diplomate with twelve or more years of experience. Salary $11,000. (This includes the 25 per cent specialists' increment). Serves as Branch Medical Director; Medical Manager of Hospital; Clinical Director or Chief of Service in a large hospital; Assistant to Branch Medical Director or, in some cases, Chief of Section in a large hospital.

Senior Grade. Must be Board diplomate with eight or more years of experience. Salary (including specialists' increment) $10,220 to $11,000. Serves as Medical Manager of a smaller hospital, Chief Medical Officer, clinical director, chief of service or chief of section in a hospital; Chief medical officer or section chief for a region or subregion, or assistant in the office of a Branch Medical Director.

Intermediate Grade. Must be eligible to take Board examinations; seven years experience. Salary $7102 to $8059 if not a Board diplomate. If a Board diplomate, salary is $8877 to $10,074. Serves as clinical director, chief of service, or chief of section in a smaller hospital; or assists chief medical officer in a Branch, Regional or Subregional office.

Full Grade. Five years experience. Salary $5905 to $6862 if not a Board diplomate; $7381 to $8577 if a Board diplomate. Service as assistant to a chief of service or section or in a Branch, Regional or Subregional Office.

Associate Grade. Three years experience. Salary is $4902 to $5905 if not a diplomate; $6127 to $7381 if a Board diplomate; serves as senior ward officer or as a physician in a Regional or Subregional office.

Junior Grade. Salary $4149 to $4902. For Board diplomates, salary range is from $5186 to $6127. Serves as a ward officer or in a Regional Office.

Length of Service: Not specified. Resignations are accepted at any time.

Promotions: Determined by special boards on basis of demonstrated ability.

Transportation: After first assignment, transfers are at government expense.

Residencies, focussed especially at training for Board examinations are available in many VA hospitals and in most specialties.

PART-TIME POSITIONS

Part-time positions are available in the New Jersey Region. Pay is commensurate with time spent, on basis of forty-hour week. For example, a physician whose training and experience would justify an "intermediate grade rating" and who is not a Board diplomate, would be based at $7102 for a forty-hour week. Thus, if he gave the VA two half days (four hours each) a week, he would receive one fifth of this salary or $1420 a year, which would represent about $28 for those two half-days a week. If he were a Board diplomate, this would be increased 25 per cent.

WHERE TO APPLY

Full Time Positions: Chief Medical Officer, Branch No. 3, Veterans Administration, 128 North Broad Street, Philadelphia 2, Penna.

Part-time Positions: Chief Medical Officer, Regional Office, Veterans Administration, 20 Washington Place, Newark 2, N. J.

Residencies: Director of Research and Education, Veterans Administration, Washington 25, D. C.

Fee-Basis (Private Office) Service: Chief Medical Officer, Regional Office, Veterans Administration, 20 Washington Place, Newark 2, N. J.

Further Information: Send for VA pamphlet 10-7, writing to Publications Division, Veterans Administration, Washington 25, D.C.

THE MEDICAL SOCIETY OF NEW JERSEY

THE CHARTER OF 1864

NOTE: The Medical Society of New Jersey was founded July 23, 1766. County societies were first chartered in 1816. In 1825 the state delegated to The Society the authority to confer the M.D. degree. The Society became an original constituent of the American Medical Association when the latter body was created in 1847. Since The Medical Society of New Jersey was older than the state government, its charter did not originally derive from the state. Accordingly, the Senate and General Assembly of the State of New Jersey enacted Chapter 157 of the Laws of 1864, chartering The Medical Society of New Jersey. The full text of the enabling act and charter follows:

CHAPTER CLVII

AN ACT TO REORGANIZE THE MEDICAL SOCIETY OF NEW JERSEY

WHEREAS, The Medical Society of New Jersey is approaching its centenary anniversary; and, whereas, the society, by petition, has expressed a desire to surrender all its special privileges and pecuniary immunities, and to reorganize, as nearly as possible, upon the voluntary basis; therefore,

1. BE IT ENACTED, *by the Senate and General Assembly of the State of New Jersey,* That the Medical Society of the State of New Jersey, already incorporated by the style and name of "The Medical Society of New Jersey", shall continue to be a body corporate and politic, in fact and in name, and shall and may have and use a common seal, and alter the same at their pleasure; and that the said society shall be composed of delegates (not less than three), chosen by and from each of the district or county societies, which now are, or which under the authority of the said society may be hereinafter instituted; the officers for the time being, shall be ex-officio members of the said society, independently of the authority of delegation; and all persons who shall have been, or may hereafter be, presidents of the society, shall rank as Fellows, and be entitled to all the privileges of delegated members.

2. *And Be It Enacted,* That the society shall have the authority to confer the degree of Doctor of Medicine, under such rules and regulations as they may adopt, which degree shall be deemed sufficient evidence of a regularly educated and qualified practitioner of the healing art; and hereafter no one shall be admitted to membership in any district or county society having connection with this society, unless he shall have received the said degree of Doctor of Medicine, or been admitted *ad eundum,* from some other medical authorities, which this society shall deem proper to recognize; *provided,* that this act shall not be so construed as to prevent any county or district society from admitting to membership any respectable practitioner who shall have previously to the passage of this act, received the degree of doctor of medicine from any college or university recognized by, or in affiliation with the body known as "The American Medical Association".

3. *And Be It Enacted,* That this society shall have the power to prescribe the duties of its officers and members, fix their compensation, assess from time to time an annuity upon the district or county societies in the ratio of their membership respectively, and adopt such rules and regulations for the due management of the concerns of this and the several district societies as may be deemed necessary; *provided,* the same be not contrary to the laws of this state; and may hold any estate, real and personal, the annual income of which shall not exceed one thousand dollars.

4. *And Be It Enacted,* That this act shall be considered a public act, and shall take effect on the fourth Tuesday of January, eighteen hundred and sixty-six; and that the act entitled "An act to incorporate medical societies for the purpose of regulating the practice of physic and surgery in this State", passed January twenty-eighth, eighteen hundred and thirty, and all supplements thereto, be and the same are hereby repealed.

Approved March 14, 1864.

CONSTITUTION OF THE MEDICAL SOCIETY OF N. J.

ARTICLE I—NAME

The name of this organization is "The Medical Society of New Jersey".

ARTICLE II—PURPOSE

The purposes of this society are:

To federate and organize the medical profession of the State of New Jersey;

To unite with similar organizations of other states to compose the American Medical Association;

To advance medical science, elevate professional standards, safe-guard the material interest of and promote friendly relations among members of the medical profession;

To educate the public in prevention of disease and the preservation of health; and, in general,

To render this profession most capable of serving humanity.

ARTICLE III—COMPONENT SOCIETIES

County medical societies that hold charters from this society shall be known, and referred to in the Constitution and By-Laws, as *component societies.*

ARTICLE IV—COMPOSITION OF THE SOCIETY

SECTION 1—OF WHOM COMPOSED

This society shall be composed of Fellows, Officers, Delegates, and members of Component Societies in good standing.

SECTION 2—GROUPS

(a) Fellows. The Fellows are the Ex-Presidents of the society.

(b) Officers. The Officers shall be a President, a President-Elect, two Vice-Presidents, a Secretary, a Treasurer, members of the Board of Trustees, and the Councilors.

(c) Delegates. Delegates shall be chosen by and from the component societies, and shall be members of this society and of the House of Delegates for the period of time for which they are elected, subject to continuance of good standing in their respective component society, and further subject to their respective component society continuing in good standing in this society.

SECTION 3—ELECTION OF DELEGATES

(a) Apportionment. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at its annual meeting by a majority ballot of the members present; but, each component society shall be entitled to at least three (3) delegates. Each component society shall, at its annual meeting next following the adoption of this Constitution, elect delegates in 3 groups, for periods of 1, 2, and 3 years, respectively; and thereafter shall elect its delegates for period of 3 years each.

(b) Reapportionment. In the event of subdivision of any of the existing counties of New Jersey and the creation of an additional component society, the delegates from the old and the new component societies shall be apportioned on the basis above provided, and the quota of the original component society of that district shall be correspondingly diminished.

(c) Delinquency. In the event that a component society becomes delinquent to this society, its entire delegation shall lose its status throughout the period of such delinquency.

(d) Vacancies. A vacancy shall exist in the delegation of any component society whenever one of its delegates ceases to be in good standing, or fails to attend two consecutive meetings (annual or special) except in case of illness, or resigns, or dies. When such a vacancy occurs in any component society, its secretary shall promptly so notify the Secretary of this society, in writing; and, after acknowledgment of receipt of such notice, the component society shall, at a regular or special meeting, fill the unexpired term of such vacancy by election of a new delegate, by a majority ballot of the members present.

(e) Alternates. Each component society shall elect, at its annual meeting, an alternate delegate for each regular delegate, and the latter, if unable to attend the annual meeting (or any regularly called meeting) of this society, shall assign his delegate's card to an alternate. An alternate, when serving, shall have all the rights and privileges of a regular delegate; and, when registered and seated in the House of Delegates, shall retain his seat during that entire meeting.

SECTION 4—MEMBERS OF COMPONENT SOCIETIES

All members of component societies in good standing are hereby constituted members of this society and entitled to participate in all the privileges of general and scientific sessions.

SECTION 5—HONORARY MEMBERS

Honorary members shall be physicians and surgeons who have attained distinction within the medical profession, and who may be elected by a two-thirds vote of the House of Delegates after having been recommended by the Committee on Honorary Membership; provided the number of living Honorary Members does not exceed fifteen (15). They shall have all the privileges of members, but shall not be members of the corporate body.

SECTION 6—GUESTS

Any physician, resident or non-resident of New Jersey, may, upon invitation of this society or its House of Delegates, become a Guest during the annual meeting, and shall thereby be accorded the full privileges of the scientific sessions.

ARTICLE V—HOUSE OF DELEGATES

The House of Delegates shall be the *legislative* body, and shall hear appeals from the decisions of the Judicial Council, and shall consist of the Fellows, Officers and Delegates.

ARTICLE VI—BOARD OF TRUSTEES

The Board of Trustees shall be the *executive* body, and shall be composed of the Junior Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district—who shall be elected as follows:

At the first election of officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.

ARTICLE VII—COUNCILORS

The House of Delegates shall organize five (5) councilor districts within the state. (See map.) This society shall elect one (1) councilor from among the membership of each such district; and these elected councilors, collectively, together with the President who shall be a member ex-officio, shall constitute the Judicial Council.

ARTICLE VIII—MEETINGS

SECTION 1—GENERAL SESSION

This society shall hold an annual meeting, during which there shall be at least one general session that shall be open to all registered members.

SECTION 2—SECTIONS

The House of Delegates or the Board of Trustees may provide for division of the scientific work of the society into appropriate sections whenever necessity therefor arises.

SECTION 3—TIME AND PLACE OF ANNUAL MEETING

The time and place for said annual meeting shall be fixed by the House of Delegates for each succeeding year. The Board of Trustees may change the time and place when necessary.

ARTICLE IX—OFFICERS

SECTION 1—TERM OF OFFICE

The Officers, except the Councilors and members of the Board of Trustees, shall hold office for one year, or until their successors are elected and installed.

SECTION 2—ELECTION

The Officers shall be elected by this society, by ballot on the second day of the annual meeting. No member shall be eligible to more than one office at the same time, except the President, President-Elect and two (2) Vice-Presidents, Secretary and Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled *ad interim* by the Board of Trustees.

ARTICLE X—FUNDS AND EXPENSES

SECTION 1—FINANCES

Current expenses of this society shall be met by an annual *per capita* assessment upon the members of each component society; by donation; by sale of the society publications; and from miscellaneous revenue. During the annual meeting, funds may be appropriated by the House of Delegates for the expenses of the annual meeting, for publications, for expenses of officers and committees, but for no other purpose, unless authorized by a two-thirds vote of the members of the House of

Delegates then present, and approved by the Board of Trustees.

SECTION 2—INCURRING EXPENSE

The Board of Trustees may incur any necessary expense *ad interim.*

ARTICLE XI—SEAL

The seal heretofore adopted and now in use shall continue, unless otherwise ordered, to be the Seal of The Medical Society of New Jersey.



Seal of The Medical Society of New Jersey

ARTICLE XII—AMENDMENTS

This Constitution may be amended by a two-thirds vote of the members present at any annual meeting, provided the proposed amendments have been considered by the Committee on Revision of Constitution and By-Laws, and that they shall have been submitted in writing at a previous annual meeting, shall have been published in the JOURNAL of this society, and officially sent to each component society at least three (3) months before the annual meeting at which final action is to be taken.

By-Laws

CHAPTER I—MEMBERSHIP

SECTION 1—PERSONNEL

The Fellows and Officers of and all the elected delegates to The Medical Society of New Jersey and the members of component societies in good standing are members of this society. Honorary members are entitled to the rights given them by the Constitution.

SECTION 2—OFFICIAL LIST OF MEMBERS

(a) March 15th in each year is the final date for closing the official list of members. Five days before this date the treasurer of each component society shall forward to the Treasurer of this society a complete list in duplicate of all paid-up members in good standing, with their correct addresses, at the same time remitting the assessment covering such membership. The Trustees shall arrange for the compiling and publication of the Official List from the lists so received by the treasurer.

(b) On the first day of March in each year, the secretary of each component society shall send to the Secretary of this society the following information: names of the officers, reporter and censors, member of the nominating committee, delegates and alternates to this society, complete list of associate members, members elected, deceased, and those who have resigned or moved from the county during the preceding year. Where members have transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given.

(c) Upon request of the Secretary, the secretary of each component society shall furnish complete lists of the names of all affiliated and non-affiliated physicians resident in the county.

(d) The Official List as published each year shall be *prima facie* evidence of the right of members to register at the annual meeting, and, unless otherwise ordered by the House of Delegates, shall form the basis of representation of each component society; except that after the Official List is printed, any component society which finds that it is entitled to additional delegates and alternates may elect these at its April or May meetings.

SECTION 3—INELIGIBILITY

No person who is under sentence of suspension or expulsion from any component society, or whose name has been dropped from its roster shall be entitled to any of the rights or privileges of this society, nor shall he be permitted to take any part in any of its proceedings, until relieved of such disability.

SECTION 4—REGISTRATION AT ANNUAL MEETING

All members and delegates in attendance at the annual meeting of this society shall write their names and addresses on an official registration card which shall be duly presented at the registration desk; failing to do so, they shall be considered as absent.

SECTION 5—CREDENTIALS

(a) All delegates shall present to the Committee on Credentials a certificate, bearing the seal of this society and the signature of its

secretary. No delegate will be permitted to register or sit as a member of the House of Delegates without such certificate, nor if the component society of which he is a delegate has not paid its annual assessment.

(b) The annual assessment of a component society shall be the dues of at least the smallest number to whom a charter may be granted to form a component society, in accordance with Chapter X, Section 2, of these By-Laws.

SECTION 6—BADGE

When a member's right to membership has been verified by the Committee on Credentials, he shall receive a certificate or badge which will be evidence of his right to the privileges of membership. No member or delegate shall be permitted to take part in the proceedings of this society until the provisions of this chapter have been fulfilled.

CHAPTER II—MEETINGS

SECTION 1—ANNUAL MEETING

This society shall hold an annual meeting at such time and place as may be fixed by the House of Delegates or by the Board of Trustees.

SECTION 2—SPECIAL MEETINGS

Special meetings of this society or of the House of Delegates shall be called by the President upon the petition of twenty or more members representing four or more component societies, or upon request of the Board of Trustees.

CHAPTER III—CONDUCTING THE SESSIONS

SECTION 1

All registered members may attend and participate in the proceedings and discussions of the general and section meetings. The general meetings shall be for the presentation of the addresses of the President and President-Elect, orations by invited guests, and scientific papers and discussions as provided for in the official program; these meetings shall be presided over by the President, President-Elect or one of the Vice-Presidents. Special section meetings shall be for the presentation of scientific papers and discussions related to the medical or surgical specialty designated and as provided for in the program; these section meetings shall be under the guidance of a presiding officer chosen by each section at its last session of the preceding annual meeting.

SECTION 2—COMMITTEES

The general and section meetings may create committees for scientific investigations of special interest or importance to the profession or public, and may receive and dispose of such committee reports; but no expense shall be incurred in connection therewith until authorized by the House of Delegates and approved by the Board of Trustees.

SECTION 3—PROGRAMS

The order of exercises, papers and discussions, as set forth in the official program, shall be followed from day to day until completed; unless otherwise ordered by the society.

SECTION 4—LENGTH OF ADDRESSES

No address or paper, with the exception of those delivered by the President, President-Elect, and invited orators, shall occupy more than twenty minutes in its delivery or reading; and no member shall speak longer than five minutes, nor more than once, on any subject, unless by permission of the society.

SECTION 5—OWNERSHIP OF PAPERS

All papers and reports presented to the society shall become its property, and when read shall be deposited with the Secretary. Permission to publish such paper in the JOURNAL of the society or in other medical journals may be granted by the Committee on Publication.

CHAPTER IV—HOUSE OF DELEGATES

SECTION 1—MEETINGS

The House of Delegates shall meet on the first day of the annual meeting of the society, but may meet in advance of or after adjournment of the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged as not to conflict with the general meetings of the society.

SECTION 2—QUORUM

Twenty members, representing at least four component societies in good standing, shall constitute a quorum. Sessions of the House of Delegates shall be open to all members of the society, but only members of the House of Delegates shall have the right of voice or vote.

SECTION 3—CHARTERS

It may issue charters to county societies applying for affiliation with this society.

SECTION 4—AUTHORITY OVER COMPONENT SOCIETIES

It shall consider the reports of component societies, and have authority to make such recommendations and adopt such measures as may be deemed effective for building up and increasing the interest of these societies.

SECTION 5—APPEALS

It shall hear and finally determine all appeals taken from decisions of the Judicial Council.

SECTION 6—FINAL AUTHORITY

The House of Delegates or Board of Trustees must approve all memorials and resolutions issued in the name of the society before they can become effective.

SECTION 7—BUSINESS DURING THE LAST SESSION

Unanimous consent shall be required for the introduction of new business at the last session of the House of Delegates during the annual meeting, except when presented by the Board of Trustees or the Committee on Finance. All new business so presented shall require a three-fourths affirmative vote for adoption.

CHAPTER V—SELECTION OF OFFICERS

SECTION 1—NOMINATING COMMITTEE

Each component society shall elect at its annual meeting one of its elected delegates to serve as a member of the Nominating Committee of this society, and one of its elected delegates alternate thereto; this elected member, or his alternate, shall present his credentials to the Secretary at the close of the first session of the annual meeting. The junior Past-President of this society shall be the member of the Nominating Committee representing the Fellows; if he shall not be able to serve, then at the close of the first session of the annual meeting the Fellows shall elect one of their number to be a member of the Nominating Committee, who shall forthwith present his credentials to the Secretary. The delegates, or their alternates so elected from their respective component societies, and the representative of the Fellows, shall compose the Nominating Committee. This committee shall meet at 8:30 p. m. on the first day of the annual meeting and report the result of its deliberations to the House of Delegates in the form of a ticket containing nominations for each of the offices to be filled, including Trustees, Standing Committees, Councilors, Delegates to the American Medical Association and to other medical organizations.

SECTION 2—PROCEDURE

(a) The Chairman of the Nominating Committee shall be the Junior Past-President of the society or the member elected by the Fellows. The committee shall elect one of its own members to serve as secretary and to call the roll of accredited members of the committee as certified by the Secretary of the society. Nominations for all offices, standing committees, delegates to the American Medical Association and other medical organizations, shall be made by individual alphabetic roll call of the counties, the representative from the Fellows being called last. The representative of each county, when its name is called, may place in nomination a candidate, second a nomination, or waive its privilege to another county. The representative of the county so favored may then nominate a candidate or second a nomination, after which the roll call will be continued from the point where it was interrupted. The representative of the Fellows may nominate a candidate or second a nomination, and shall have a vote equal to the vote of a representative of a component society. The secretary shall announce the result on the completion of each call; and if the tabulation of any roll call be challenged, the roll will again be called. A majority vote of the members present shall nominate; and in the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped and the call of the roll shall be repeated until a nomination is made.

(b) The Secretary of the society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all officers, committees and delegates to be nominated.

(c) Nothing in this section is to be construed as preventing the nomination and election of Fellows to the Board of Trustees.

(d) The election of Trustees shall conform to the provisions of Article VI of the Constitution.

(e) The chairman shall read to the committee this section of the By-Laws (Section 2, Chapter V) before proceeding to any other business.

SECTION 3—TIME OF REPORT

The report of the Nominating Committee, and the election of officers, standing committees, delegates to the American Medical Association and other medical organizations, shall be the first order of business of the society in the afternoon of the second day of the annual meeting.

SECTION 4—NOMINATIONS FROM THE FLOOR

Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the society; except that the President-Elect shall succeed to the office of President without process of nomination and election.

SECTION 5—MANNER OF VOTING

All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

SECTION 6—BEGINNING OF TERM OF OFFICE

Officers and members of elected standing committees shall assume office immediately after adjournment of the annual meeting at which they were elected.

CHAPTER VI—DUTIES OF OFFICERS

SECTION 1—PRESIDENT

The President shall preside at all meetings of this society and of the House of Delegates. He shall appoint all committees not otherwise provided for, and shall be ex-officio member of all standing committees except the Nominating Committee. He shall deliver an address at the annual meeting of this society, and shall perform such other duties as custom and parliamentary usage may require.

SECTION 2—PRESIDENT-ELECT AND VICE-PRESIDENTS

The President-Elect and the Vice-Presidents shall assist the President in the discharge of his duties, and in his absence or disability the President-Elect, or the ranking Vice-President shall preside at all meetings of the society and of the House of Delegates, and perform all the duties pertaining to the office. In case of vacancy in the office of President by death, resignation, or removal, the President-Elect, and in his absence, the ranking Vice-President shall perform all duties pertaining to that office until the vacancy is filled by appointment of the Board of Trustees.

SECTION 3—SECRETARY

The Secretary of the society shall have the custody of the Constitution and By-Laws of the society and of the records of the society and the House of Delegates, under the direction of the Board of Trustees. He shall attend all meetings of the society and of the House of Delegates, and shall keep a record of their proceedings. He shall give notice of all general and special meetings of the House of Delegates or of the society, to the members of the said House or society. He shall notify Honorary Members of their election.

He shall require and receive from the secretaries of the county societies a list of their representatives in the House of Delegates and the Nominating Committee, and shall publish such lists at such times and in such manner as the House of Delegates may direct.

He shall have the sole custody of the Official Seal of the society and shall affix the same to such correspondence or instruments as the By-Laws may require or the Trustees or the President may direct.

He shall conduct such formal official correspondence in the corporate name of the society as the Trustees or the President may direct. The Board of Trustees shall make suitable provision for the detail and clerical work of the Secretary.

He shall submit annually to the House of Delegates a report of the work of his office, and shall furnish to the Board of Trustees or to the President, upon request, such information as may be necessary for the society's business, and shall perform such other functions as are specified in these By-Laws.

He shall be entitled to necessary expense in attending meetings or otherwise incurred in the transaction of the society's business, as authorized by the Trustees.

SECTION 4—TREASURER

The Treasurer shall give bond, at the expense of the society, in such amount as may be required by the Board of Trustees. He shall demand, receive and preserve all funds due the society, together with bequests and donations; and keep a correct list of the same, with the name of each donor. He shall not pay any money out of the treasury except on resolution of the Board of Trustees, or upon voucher of the officer or committee responsible for the

expenditure, countersigned by the Chairman of the Finance Committee, and as provided in the annual budget. His accounts shall be audited by the Trustees at such times as the Board or the House of Delegates may order, and he shall render at each annual meeting of the society a full statement of all transactions of his office. Whenever 90 per cent of the annual budget appropriated for any office or committee has been expended, he shall so notify the proper officer or committee chairman. He shall charge upon his books the assessment against each component society at the end of the fiscal year, collect and make proper credits for the same; and perform such other duties as may be assigned to him.

SECTION 5—BOARD OF TRUSTEES

(a) Organization. At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the Board shall organize by electing a chairman and a secretary; and the chairman shall appoint such committees as may seem necessary or desirable. Meetings shall be called by the chairman, but any four members may require the chairman to call a meeting for such time and place as shall be designated by them in writing. Members shall have at least five days advance notice of all meetings. Nine members shall constitute a quorum.

(b) Powers. The Board shall exercise general supervision over the affairs of the society, with authority to act for the society between annual meetings, and to perform the following functions:

To make recommendations to the House of Delegates;

To advise in the deliberations of the several standing committees;

To supervise the work of the Publication Committee and, when necessary, to appoint an editor and such other assistants as the needs of the society may require;

To determine all salaries;

To pass upon all recommendations for incurring expense, over and above that provided in the budget;

To order all necessary expenditures;

To refer and otherwise dispose of all business, properly arranged for its disposition;

To require and hold the official bond of the Treasurer and to annually audit his accounts;

To fill vacancies in all offices and elected standing committees until the next annual meeting.

In the event of a vacancy in the office of Treasurer, by death or otherwise, the Board of Trustees shall select one of its members to fill the vacancy.

(c) Property. It shall have authority to lease, sell, or otherwise convey or dispose of any or all property of the society, both personal and real, and to execute therefor, good and sufficient lease, deed, or other conveyance.

(d) Finance Committee. Three of its members shall serve on the Committee on Finance in accordance with Chapter VIII, Section 5, of these By-Laws.

(e) Nominees to State Board of Medical Examiners. Acting for the society, and in accordance with the statutes of this state, as vacancies occur in the State Board of Medical Examiners by reason of the expiration of term, or otherwise, of members of said Board representing this society, the Trustees shall nominate for each appointment three members of this society, and the names of such nominees shall then be transmitted by the President of this society to the Governor of the state.

(f)—Annual Report. It shall publish annually in the JOURNAL of this society a report of its proceedings and recommendations, and shall render to the House of Delegates a summary of its activities.

CHAPTER VII—JUDICIAL COUNCIL

SECTION 1—ELECTION

The Councilors shall be elected as follows: At the first election of officers following the adoption of these By-Laws, two (2) members shall be elected for a period of three (3) years; two (2) members for a period of two (2) years; and one (1) for a period of one (1) year; and as the terms of these elected Councilors expire, new elections shall be for periods of three (3) years. The President shall be a member of the Council ex-officio.

SECTION 2—CENSORS

The Councilors collectively, shall constitute a Board of Censors of this society known as the Judicial Council.

SECTION 3—MEETINGS

The Judicial Council shall meet on the evening before the annual meeting of the society, and subsequently at the call of the chairman or upon the petition of three of the Councilors, at such time and place as necessity or convenience require. Four members shall constitute a quorum.

SECTION 4—ETHICS AND DISCIPLINE

All questions of an ethical nature shall be referred by the House of Delegates or the Board of Trustees without discussion to the Judicial Council. It shall consider and decide all questions of discipline affecting the conduct of members. It shall consider all questions involving the rights of members, whether in relation to each other, to component societies, or to this society.

SECTION 5—APPEALS

(a) Any aggrieved member of a Component Society may appeal from the decision or action of the County Medical Society to the Judicial Council of The Medical Society of New Jersey. After ninety (90) days from the day of filing his appeal to the County Medical Society for a hearing, such aggrieved member, if he so desires, may appeal directly to the Judicial Council upon declaration that he has appealed to and been denied, or has not received, a hearing by his County Medical Society. An applicant who may have been excluded from membership in a County Medical Society may appeal from its action to the Judicial Council of the State Medical Society.

(b) The notice of appeal shall set forth in writing the name of the appellant, the name of such component society, the date and substance of the questioned decision, and shall indicate the grounds upon which such appeal is taken.

(c) Upon filing a notice of appeal, the appellant and the component society must submit to the Secretary of this society all records, minutes, letters, papers and written evidence, including a digest of all testimony whether or not stenographically reported, relative to the matter. All data so submitted shall be confidential and privileged, and made available only to the Judicial Council and its respective members. In case of an appeal being taken from the decision of the Council to the House of Delegates, all such data must then be submitted to the House of Delegates or to a committee appointed by that body to consider the appeal.

(d) The Judicial Council shall consider any appeal on the data so submitted, and may affirm by a majority vote, modify, or reverse by a two-thirds vote of its members present and voting, the appealed decision. If, in its opinion, further evidence is desirable, the Judicial Council may summon witnesses, take such evidence in any manner it may deem proper, and render its decision by a two-thirds vote of the members present and voting; and all its decisions shall be binding unless or until reversed or modified by the House of Delegates.

CHAPTER VIII—COMMITTEES

SECTION 1—CLASSIFICATION

There shall be Standing Committees, Reference Committees, and Special Committees.

SECTION 2—STANDING COMMITTEES

The Standing Committees shall be:
Nominating Committee
Committee on Finance
Committee on Scientific Work
Committee on Annual Meeting
Publication Committee
Honorary Membership Committee
Welfare Committee
Post-Graduate Education Committee
Medical Defense and Insurance Committee
Woman's Auxiliary Committee
and such other committees as the House of Delegates shall determine.

SECTION 3—APPOINTMENTS

Standing Committees, unless otherwise provided, shall be appointed by the President, and he shall designate the chairmen. The President shall be a member ex-officio of all the above named committees except the Nominating Committee. Unless otherwise ordered in these By-Laws, committee members shall serve for three years; provided that in committees of three members no two terms shall expire in the same year; and in committees of six members not more than two terms shall expire in the same year.

SECTION 4—NOMINATING COMMITTEE

The Nominating Committee shall be selected and shall function according to the provisions of Chapter V of these By-Laws.

SECTION 5—COMMITTEE ON FINANCE

The Committee on Finance shall consist of three members elected by and from the Board of Trustees, and three members elected by and from the House of Delegates, and their term of office shall be for six years; provided that the term of one Trustee member shall expire every second year, and the term of one Delegate member on each alternate year. The Treasurer shall be a member ex-officio, his capacity being advisory and without vote except in case of tie. The committee shall elect its own chairman. It shall prepare a budget to be submitted to the House of Delegates at the annual meeting, and it shall control the expenditure of money by officers and committees, as provided in Chapter IX of these By-Laws. The committee is hereby authorized to require from any officer or committee any necessary fiscal information.

SECTION 6—COMMITTEE ON SCIENTIFIC WORK

The Committee on Scientific Work shall consist of one member from each councilor district to be chosen by the House of Delegates, and two members appointed by the President. Those who are to be elected are as follows:

At the first election one (1) member shall be elected for a period of one (1) year; one (1) member for a period of two (2) years; one (1) member for a period of three (3) years; one (1) member for a period of four (4) years; and one (1) member for a period of five (5) years; and as the terms of these members expire, new elections shall be for periods of five (5) years each.

The members who are to be appointed by the President shall be appointed as follows:

The first appointment shall be for a period of one (1) year; and the second appointment for a period of two (2) years; and as the terms of these members expire, new appointments shall be for periods of two (2) years.

It shall choose its own chairman and secretary.

The duties and functions of this committee shall be:

(a) To collect information, through the county reporters or otherwise, of members who are interested in prosecuting scientific studies or research, privately or in hospitals, schools, health departments, or other agencies in the state;

(b) To support and encourage such work, as means and opportunity may be available, and in general to promote interest in original scientific work among the members of the society;

(c) To facilitate contacts and exchanges between workers in related fields in different parts of the State;

(d) To facilitate the presentation of such work and its results to the society, either at its meetings, through the committees in charge, or in the JOURNAL, through the Publication Committee.

SECTION 7—COMMITTEE ON ANNUAL MEETING

The Committee on the Annual Meeting shall consist of five members. It shall have complete charge of all arrangements, plans and programs for the annual meeting and all details pertaining thereto. It shall provide suitable accommodations for the annual meeting, viz: for the general and section sessions, house of delegates, trustees, committees, woman's auxiliary, and exhibits. The general plans for the annual meeting shall be subject to the approval of the Board of Trustees and shall be reported to them at intervals, with a complete outline at least four months before the meeting.

This committee shall have two sub-committees, one on *scientific program* and one on *scientific exhibits.*

One member of the committee shall be designated by the chairman, with the consent of the President, as Chairman of the Sub-Committee on Scientific Program. It shall be his duty to arrange for papers, addresses and orations for the annual meeting. He shall see that the speakers are properly received at the annual meeting and that the scientific papers are delivered as scheduled. He may appoint two other men to assist him in the work of this sub-committee. The classification and number of scientific sections shall be determined by this sub-committee. The chairman and secretary of the scientific sections shall be elected by each section, but shall be responsible to the chairman of the scientific program and shall report to him.

Another member of the Committee on Annual Meeting shall be designated by the chairman, with the consent of the President, as the Chairman of the Sub-Committee on Scientific Exhibits. He may in turn designate two other members with the consent of the chairman, to act as a sub-committee on scientific exhibits. The duty of this sub-committee shall be to prepare and arrange for all details in connection with scientific exhibits of the annual meeting.

SECTION 8—PUBLICATION COMMITTEE

The Committee on Publication shall consist of three members elected by the House of Delegates, with the Secretary an additional member ex-officio, and the Editor of the JOURNAL sitting with the committee in an advisory capacity. It shall publish and distribute the JOURNAL. Reports, papers, and discussions may be submitted to this committee for publication in the JOURNAL; but the committee shall have authority to curtail or abstract, or to return to the author, such material as seems to it unsuitable for publication, with a statement of the reasons therefor.

SECTION 9—HONORARY MEMBERSHIP COMMITTEE

The Committee on Honorary Membership shall be composed of three Fellows. It shall inquire into the standing and qualifications of all nominees for honorary membership in the society, and report the same with recommendations to the House of Delegates.

SECTION 10—WELFARE COMMITTEE

The Welfare Committee shall consist of thirty-five (35) members, appointed annually, which number shall include the President and Secretary of this society, ex-officio. Each component county society shall be represented by at least one member, and candidates for such appointment may be suggested to the President by each component society. It shall keep minutes and records of its transactions. It shall have supervision over legislative matters, public health, public relations and medical practice, subject, when necessary, to direction from or approval by the Board of Trustees or the House of Delegates. To this committee shall be referred all questions of professional welfare not included in the specific work of the Judicial Council. It shall be empowered to employ a special agent or agents, and to expend such moneys as shall be approved by the Committee on Finance and the Board of Trustees. The work of this committee shall be divided into four sub-committees—public health, legislative, medical practice, and public relations. Each sub-committee shall consist of five members appointed annually and its chairman shall be appointed by the chairman of the Welfare Committee with the approval of the President. Special Advisory Committees, of five members each, to these committees may be formed on the approval of the Board of Trustees, and the members shall be appointed by the President.

SECTION 11—COMMITTEE ON POST-GRADUATE EDUCATION

The Committee on Post-Graduate Education shall consist of five members. The first appointment shall be for a period of one (1) year; the second appointment shall be for a period of two (2) years; the third appointment shall be for a period of three (3) years; the fourth appointment shall be for a period of four (4) years; the fifth appointment shall be for a period of five (5) years; and as the terms of these members expire, new appointments shall be for periods of five years. It shall be the duty of this committee to provide a continuous program of post-graduate education for the members within the resources of the society. It shall advise upon, correlate and promote all of the post-graduate activities of the special committees in cooperation with educational institutions.

SECTION 12—COMMITTEE ON MEDICAL DEFENSE AND INSURANCE

The Committee on Medical Defense and Insurance shall consist of five members, and shall have charge of all matters pertaining to alleged malpractice of members and all other types of insurance, such as health, accident, life, and automobile, which may be recommended to the members.

It shall have the responsibility for the protection of the members and the contracts and relations with the insurance company. It shall at all times be cognizant of the financial responsibility of the insurance companies, brokers, and agents with whom it is dealing, and shall make frequent reports to the Board of Trustees and annually to the House of Delegates on these matters. It shall not enter into contracts without the approval of the Board of Trustees or the House of Delegates. It shall maintain contact with the Judicial Council and refer complaints of an ethical nature to that body.

SECTION 13—REFERENCE COMMITTEES

Immediately after the organization of the House of Delegates at each annual meeting the President shall appoint, from the members of the House, reference committees of five members each, unless otherwise provided, to serve during the session at which they are appointed. To these committees may be referred any reports, resolutions, measures, or propositions which have been presented to the House. When a matter is referred to any such committee, it shall meet forthwith, discuss the question referred, and hear debate thereon by any interested member of the society; and shall submit its recommendations at the next session of the House for action.

SECTION 14—NAMES OF REFERENCE COMMITTEES

There shall be the following Reference Committees, and any others to be created by the House of Delegates as need arises:

(a) Credentials—to consist of one member to serve with the Secretary and the Treasurer, who are members ex-officio.
(b) Resolutions and Memorials.
(c) Constitution and By-Laws.
(d) Miscellaneous Business.

SECTION 15—CONTINUANCE OF FUNCTION

On the order of the President or House of Delegates any reference committee may be

created a *special* committee in order to continue, after the annual meeting, work which has been initiated but which cannot be completed during that meeting; but there shall be a strict limitation, in the order for its continuance, as to its function and term of life.

SECTION 16—SPECIAL COMMITTEES

Special committees may be created by the House of Delegates or by the Board of Trustees. They shall be appointed by the President, or the Chairman of the Board of Trustees, and their specific functions and term of life shall be clearly defined. The limitations in regard to incurring expense provided for in Chapter III, Section 2, of these By-Laws shall apply also to these committees.

SECTION 17—ADDING TO SIZE OF COMMITTEE

The President may at any time, on request of any committee, appoint additional members thereto, in order to meet unexpected or unusual demands on that committee; provided that the term of such emergency appointees shall cease with the close of the next annual meeting of the society.

CHAPTER IX—FINANCE

SECTION 1—PERMANENT FUND

(a) There is hereby established in the custody of the Treasurer a Permanent Capital Fund, to consist of any money which may come to The Medical Society of New Jersey by gift or bequest and not otherwise designated, any balance remaining unexpended at the close of the fiscal year which the Board of Trustees may direct to be added to this fund, and such other money as may from time to time be available for this purpose.

(b) This fund shall be deposited or invested by the Treasurer in such manner as is by law provided for trust funds, or as the Board of Trustees may direct. The income from such funds may be used for the general purposes of the society, unless otherwise ordered, but the principal of the fund may be expended only for purposes of permanent value to The Medical Society of New Jersey, when so ordered by a two-thirds vote of the House of Delegates, such expenditure having previously been approved by the Board of Trustees and notice of such approval sent to the component societies at least one month in advance of the meeting of the House of Delegates at which action is taken.

SECTION 2—GENERAL FUND

(a) Annual Assessment of Members. On the first day of January in each year there shall be levied on each component society a *per capita* assessment on the membership of such component society, as hereinafter set forth (Par. b), to be paid to the Treasurer of the Medical Society of New Jersey not less than five days before the first of March, together with a list of the members for whom such payment is made. A similar *per capita* assessment shall be paid in the same manner immediately upon the admission or reinstatement of any such member, except that for a new member admitted after October first of any calendar year one-quarter of the regular assessment shall be paid. Every member for whom the assessment is paid shall be listed as a subscriber to and entitled to receive the JOURNAL.

(b) Estimating the Assessment. Two weeks before the annual meeting each officer and standing committee shall send to the Chairman of the Committee on Finance an estimate of the amount of money necessary for the work of his office during the next fiscal year. The Committee on Finance shall then proceed to consider and determine the amount of money to be raised, fix the *per capita* assessment to be levied on the component societies, and report its recommendations to the House of Delegates at the first session of that body. This report may then be approved, amended, or rejected by the House of Delegates, but final action on it shall not be taken before the last session of the meeting.

(c) The Budget. No officer or committee may spend more money than the amount allowed in the budget without approval of the Committee on Finance, which may, however, apportion to such officer or committee, on application, any unexpended balance of other items; provided that the total amount disposed of by the Finance Committee must not exceed the total amount voted by the House of Delegates, unless by special authority of the Board of Trustees.

SECTION 3—FISCAL YEAR

The fiscal year of the society shall begin on the first day of June, and the financial report of the Treasurer and of all officers and committees shall be for this period. The budget estimates and appropriations shall likewise be for the same period.

SECTION 4—BUDGETS

All motions and resolutions appropriating money for special purposes shall fix a definite sum, and shall state the budget account against which the expenditure is to be charged. Such resolution must be passed by the House of Delegates and approved by the Board of Trustees.

CHAPTER X—COMPONENT SOCIETIES

SECTION 1—CHARTERS

County medical societies of this state that shall adopt the principles of organization in accord with the Constitution and By-Laws of this society may, upon application to the House of Delegates, receive a charter, and thereby become a component society in affiliation with The Medical Society of New Jersey as hereinafter provided.

SECTION 2—CONDITIONS OF CHARTERING

Charters shall be issued to county societies having at least ten members, under seal of The Medical Society of New Jersey and signed by the President and Secretary; but there shall be only one component society chartered in each county. Upon recommendation of the Board of Trustees, this society may revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and By-Laws.

SECTION 3—QUALIFICATIONS OF MEMBERS

(a) Judging Qualifications. Each component society shall be the judge of the qualifications of its own members, subject to the right of approval of this society; but, as such societies are the only portals to this society and to the American Medical Association, it is recommended that every reputable and legally registered physician shall be deemed eligible to membership in a component society.

(b) Biographies of New Members. When a physician applies for membership or when an application is made to be received on transfer, the secretary of the component society shall forward his name and address to the biographic department of the American Medical Association for such information as may be on file relative to his record. Printed forms for this purpose will be furnished by the Secretary of this society. After the adoption of these By-Laws, no new member shall be enrolled or accepted on transfer until this provision shall have been carried into effect.

(c) Probationary and Associate Members. Each component society, as a requisite of eligibility to active membership, may require applicants to serve a probationary period of not longer than two years in the society as *associate members.* Associate members shall have such privileges in component societies as the Constitution and By-Laws of the respective societies may provide, except the right to vote and hold office. Their dues shall be those fixed by their respective component society, plus the subscription price of the Journal as determined by the Board of Trustees.

(d) (Explanatory note. — The following resolution defining courtesy members was passed by the House of Delegates, April 29, 1937: "Associate members of component societies shall be physicians who may be elected to active membership after a period of probation. All others now called associate members shall be termed *courtesy members.*" Transactions, 1937, page 50.)

SECTION 4—APPEALS

Any physician who may feel aggrieved by the action of a component society in refusing him membership, or any member of a component society who has been suspended or expelled, shall have the right of appeal through his District Councilor to the Judicial Council. The powers of the Judicial Council and its method of procedure are defined in Chapter VII of these By-Laws.

SECTION 5—TRANSFERS

When a member in good standing in a component society moves to another county of this state, his name, upon request, may, by a majority vote of those present, be transferred to the roster of the component society into whose jurisdiction he moves.

SECTION 6—JURISDICTION

Any physician living on or near a county line may hold his membership in the component society most convenient for him to attend, on permission from the component society in whose jurisdiction he resides; *provided that* no physician may be a member of two component societies at the same time, nor of this society and another state society.

SECTION 7—REPORTERS

Each component society shall elect a reporter, who shall furnish the Editor and the Secretary of the Committee on Scientific Work with brief reports of its meetings and of items of interest concerning the society and its members, extracts of papers and interesting case reports, notice of the prevalence of contagious and other diseases in the county, and the election, removal or death of members.

CHAPTER XI—RESIGNATION OR REMOVAL OF OFFICERS

Any officer of this society may resign his office, or he may be removed therefrom by a two-thirds vote of the House of Delegates, when guilty of neglect of duty, improper conduct, or upon violation of the Constitution and By-Laws. In either or all cases the society shall fill the vacancy so made as provided for in Article IX of the Constitution, and in Chapters V and VI of the By-Laws.

CHAPTER XII—RULES OF CONDUCT

The "Principles of Medical Ethics" adopted by the American Medical Association shall govern the conduct of the members of The Medical Society of New Jersey in their relations to each other and to the public.

CHAPTER XIII—RULES OF ORDER

The deliberations of the society shall be governed by parliamentary usage as contained in Roberts' "Rules of Order", when not in conflict with this Constitution and By-Laws, unless otherwise determined by a two-thirds vote of its respective bodies.

CHAPTER XIV—CONFERRING THE DEGREE OF DOCTOR OF MEDICINE

Candidates for the degree of Medicinae Doctor may apply to any component society of this state, and shall be admitted to examination under the following rules and regulations:

First. Each component society shall appoint annually, or *pro re nata,* a committee of not less than five members, who shall conduct the examinations.

Second. All examinations shall be in the presence of The Medical Society of New Jersey at a regular meeting; and no candidate shall be examined until he has given satisfactory evidence of having reached the age of twenty-one years, is of good moral character, that his preliminary education has been such as to qualify him for the study and practice of medicine, and has pursued his medical studies in some medical college whose requirements do not fall below the minimum standard of the Association of American Medical Colleges.

Third. The examination shall extend to all of the branches taught in the medical schools recognized as aforesaid; and the candidate shall then be balloted for by The Medical Society of New Jersey. If he shall receive the approving votes of two-thirds of all the members present, the presiding officer shall give a certificate to that effect to the candidate.

Fourth. The certificate may be presented at the next or any subsequent regular meeting of The Medical Society of New Jersey, not extending beyond the period of three years, with a written thesis upon some medical subject; and if, upon a ballot, he shall be approved by a majority of the members present, the candidate, upon the payment of fifteen dollars, shall be entitled to receive a diploma in the following form:

This will certify that we . . . . . censors of the District Medical Society for the County of . . . . . appointed by The Medical Society of New Jersey, have this day carefully and impartially examined . . . . . of . . . . . county of . . . . . state of . . . . . and being well satisfied with his attainments in the various branches of Medical and Surgical Science and of his moral character do recommend him to the president of The Medical Society of New Jersey as a proper person to receive a license to practice physic and surgery throughout the state of New Jersey.

CHAPTER XV—AMENDMENTS

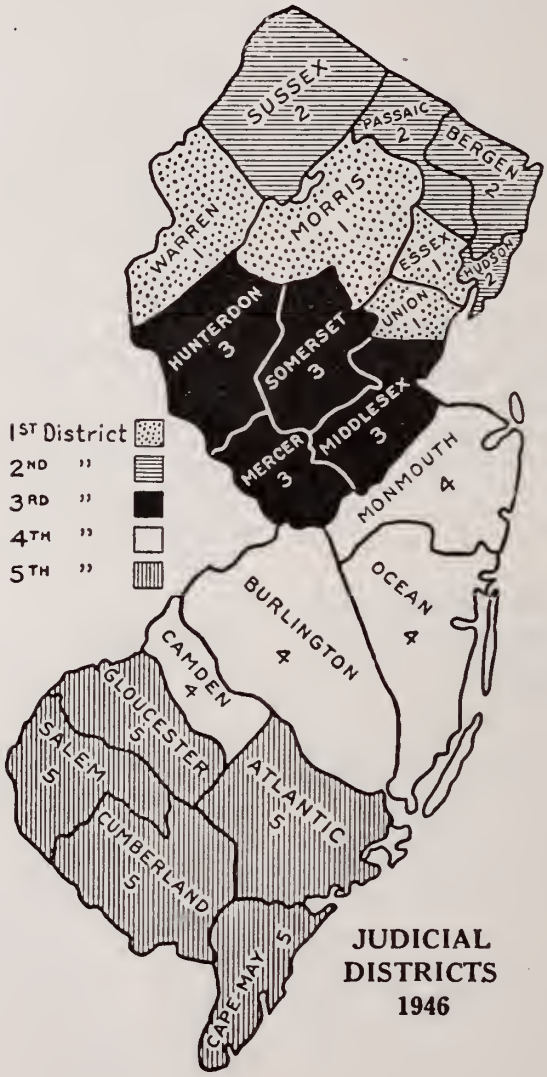
These By-Laws may be amended at any annual meeting of The Medical Society of New Jersey by a two-thirds vote of the members present, provided that at least fifty members are present; and, provided further, that the amendments shall have been submitted to the Committee on Constitution and By-Laws, and shall have been twice read in open meeting and laid upon the table for one day.

Upon the adoption of this Constitution and these By-Laws all previous Constitutions and By-Laws are thereby repealed.

COUNTIES AND JUDICIAL DISTRICTS

— OF —

THE MEDICAL SOCIETY OF NEW JERSEY



CLINICAL TABLES

Normal Blood Constants

Albumin	4 to 7 Gm/100 cc
Bilirubin	0.2 mg/100 cc
Bleeding time	1 to 2 minutes
Calcium	10 mg/100 cc
Coagulation time	4 to 6 minutes
Chlorides	700 mg NaCl /100 cc
Creatinine	2 mg/100 cc
Fatty acids	280 to 430 mg/100 cc
Globulin	2 Gm/100 cc
Nonprotein nitrogen	25 to 50 mg/100 cc
pH	7.3 to 7.4
Phosphorus	3 to 5 mg/100 cc
Potassium	16 to 22 mg/100 cc
Protein, total	6½ to 8½ Gm/100 cc
Sugar	80 to 120 mg/100 cc
Urea nitrogen	12 to 15 mg/100 cc
Uric acid	1 to 3 mg/100 cc

Normal Spinal Fluid

Calcium	2½ to 11½ mg/100 cc
Chlorides	725-750 mg/100 cc
Cells	1 to 10 per cubic mm.
Magnesium	3 mg/100 cc
Pressure	100 -200 mm. of water
Pressure	7 to 14 mm. mercury
Protein	25 to 45 mg/100 cc
Sugar	40 to 80 mgm/100 cc

Average Heights and Weights of Children

Weight (pounds)	Age	Height (inches)
11	3 months	23
16	6 months	26
18	9 months	27
21	12 months	28
23	18 months	31
26	2 years	33
29	2½ years	35
31	3 years	36
35	4 years	39
40	5 years	41
44	6 years	43
48	7 years	44
53	8 years	46
59	9 years	48
65	10 years	50
80	12 years	55
99	14 years	61
119	16 years	64

Blood Types

Jansky	I	II	III	IV
Landsteiner	O	A	B	AB
Moss	IV	III	II	I
Frequency	45	41	10	4

Blood Group	Serum agglutinates cells of	Cells are agglutinated by serum of
O	A, B and AB	none
A	B and AB	O and B
B	A and AB	O and A
AB	no type	O, A and B

Reflex Centers

Reflex	Spinal Center
Biceps	5 and 6 cervical
Radial	6 and 7 cervical
Triceps	7 and 8 cervical
Ulnar	8C and 1 thoracic
Abdominal	10-T and 1 lumbar
Knee jerks	2, 3, 4 lumbar
Ankle jerk	1 and 2 sacral

SIMPLIFIED CONVERSION TABLE

The following conversion table was prepared jointly by the U. S. Pharmacopeia, the National Formulary and the NNR editors for the American Medical Association. It also enjoys the approval of the Federal Food and Drug Administration.

Recent action by the American Medical Association in adopting the metric system only for its publications, and general recognition of the desirability and wisdom of such a policy in all of the related fields of medicine and pharmacy, led to the preparation of this table as a means of placing primary emphasis upon metric rather than upon apothecary doses and simplifying the former. Heretofore, metric doses were usually based upon a primary apothecary dose and were relatively accurate equivalents. For example, 32 milligrams and 325 milligrams were considered as dose equivalents for ½ grain and 5 grains respectively. However, when one thinks primarily in terms of the metric system the logical doses in the above cases become 30 mg. and 300 mg., both of which will be just as efficient therapeutically as were their counterparts, 32 mg. and 325 mg. Actually the metric dose quantities now accepted are those which have been used in the Pharmacopoeia since 1916 when the U.S.P. IX made its appearance.

Table on next page.

WEIGHT

Metric	Approximate Apothecary Equivalents
30 Gm.	1 ounce
15 Gm.	4 drachms
10 Gm.	2½ drachms
7.5 Gm.	2 drachms
6 Gm.	90 grains
5 Gm.	75 grains
4 Gm.	60 grains
3 Gm.	45 grains
2 Gm.	30 grains
1.5 Gm.	22 grains
1 Gm.	15 grains
0.75 Gm.	12 grains
0.6 Gm.	10 grains
0.5 Gm.	7½ grains
0.4 Gm.	6 grains
0.3 Gm.	5 grains
0.25 Gm.	4 grains
0.2 Gm.	3 grains
0.15 Gm.	2½ grains
0.12 Gm.	2 grains
0.1 Gm.	1½ grains
75 mg.	1¼ grains
60 mg.	1 grain
50 mg.	¾ grain
40 mg.	2/3 grain
30 mg.	½ grain
25 mg.	⅜ grain
20 mg.	⅓ grain
15 mg.	¼ grain
12 mg.	1/5 grain
10 mg.	1/6 grain
8 mg.	⅛ grain
6 mg.	1/10 grain
5 mg.	1/12 grain
4 mg.	1/15 grain
3 mg.	1/20 grain
2 mg.	1/30 grain
1.5 mg.	1/40 grain
1.2 mg.	1/50 grain
1 mg.	1/60 grain
0.8 mg.	1/80 grain
0.6 mg.	1/100 grain
0.5 mg.	1/120 grain
0.4 mg.	1/150 grain
0.3 mg.	1/200 grain
0.25 mg.	1/250 grain
0.2 mg.	1/300 grain
0.15 mg.	1/400 grain
0.12 mg.	1/500 grain
0.1 mg.	1/600 grain

LIQUID MEASURE

Metric	Approximate Apothecary Equivalents
1000 cc.	1 quart
750 cc.	1½ pints
500 cc.	1 pint
250 cc.	8 fluidounces
200 cc.	7 fluidounces
100 cc.	3½ fluidounces
50 cc.	1¾ fluidounces
30 cc.	1 fluidounce
15 cc.	4 fluidrachms
10 cc.	2½ fluidrachms
8 cc.	2 fluidrachms
5 cc.	1¼ fluidrachms
4 cc.	1 fluidrachms
3 cc.	45 minims
2 cc.	30 minims
1 cc.	15 minims
0.75 cc.	12 minims
0.6 cc.	10 minims
0.5 cc.	8 minims
0.3 cc.	5 minims
0.25 cc.	4 minims
0.2 cc.	3 minims
0.1 cc.	1½ minims
0.06 cc.	1 minim
0.05 cc.	¾ minim
0.03 cc.	½ minim

NOTE—A cubic centimeter is the approximate equivalent of a milliliter.

Copies of this table, printed on cards for doctor's desk use are available on request directed to Committee of Revision, U.S. Pharmacopeia, 4738 Kingsessing Avenue, Philadelphia 43, Penna. Ask for the new *Table of Metric Doses with Approximate Apothecary Equivalents.*

TEMPERATURE CONVERSION

To convert Centigrade degrees to Fahrenheit, add 40 to the given number of Centigrade degrees; multiply by 9/5 and then subtract 40.

To convert Fahrenheit degrees to Centigrade, add 40 to the given number of Fahrenheit degrees, multiply by 5/9 and then subtract 40.

CONVERSION OF CLINICAL TEMPERATURES

F	C	F	C	F	C	F	C
98	36.7	100	37.8	102	39	105	40.6
98.6	37	100.4	38	103	39.5	105.8	41
99	37.2	101	38.5	104	40	106.6	41.5

THE N.Y. ACADEMY OF MEDICINE
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OF

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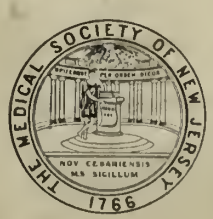
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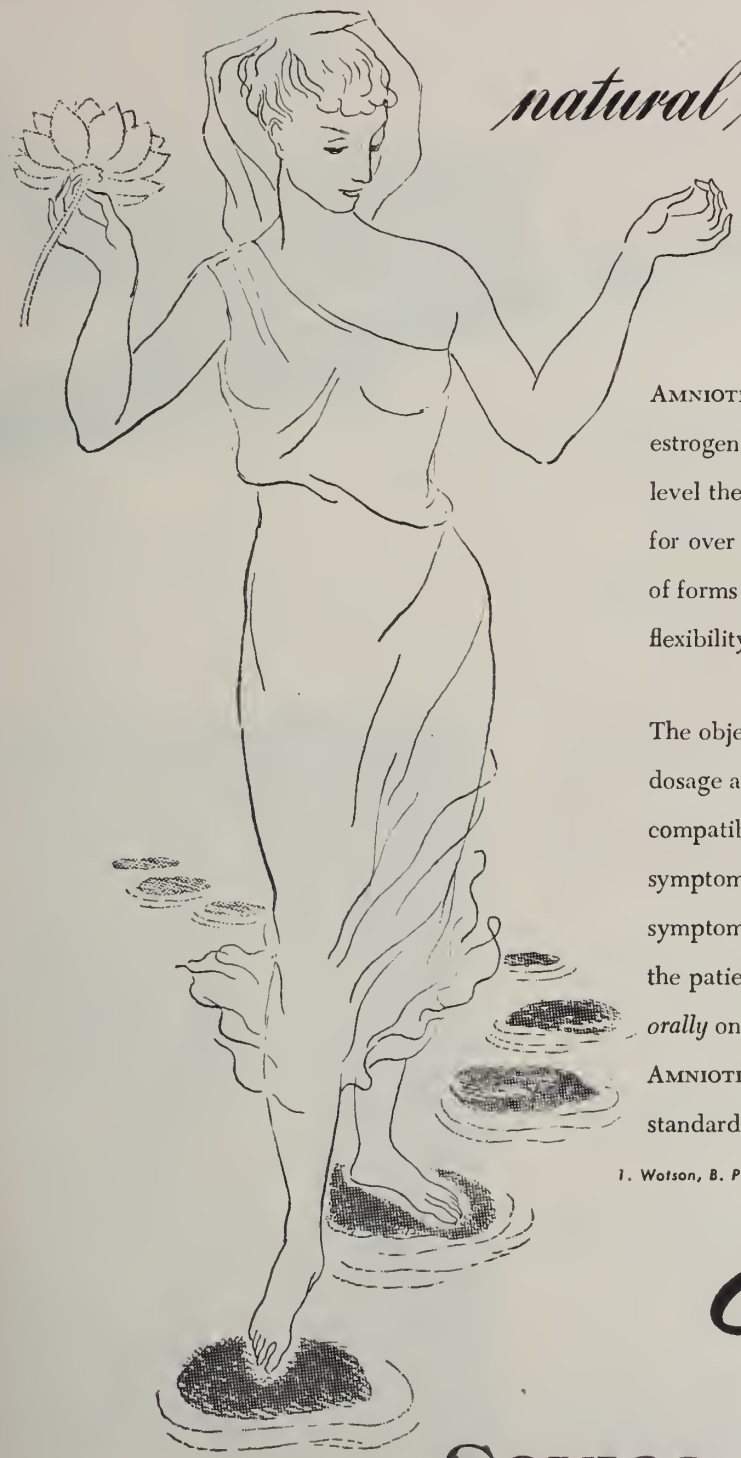
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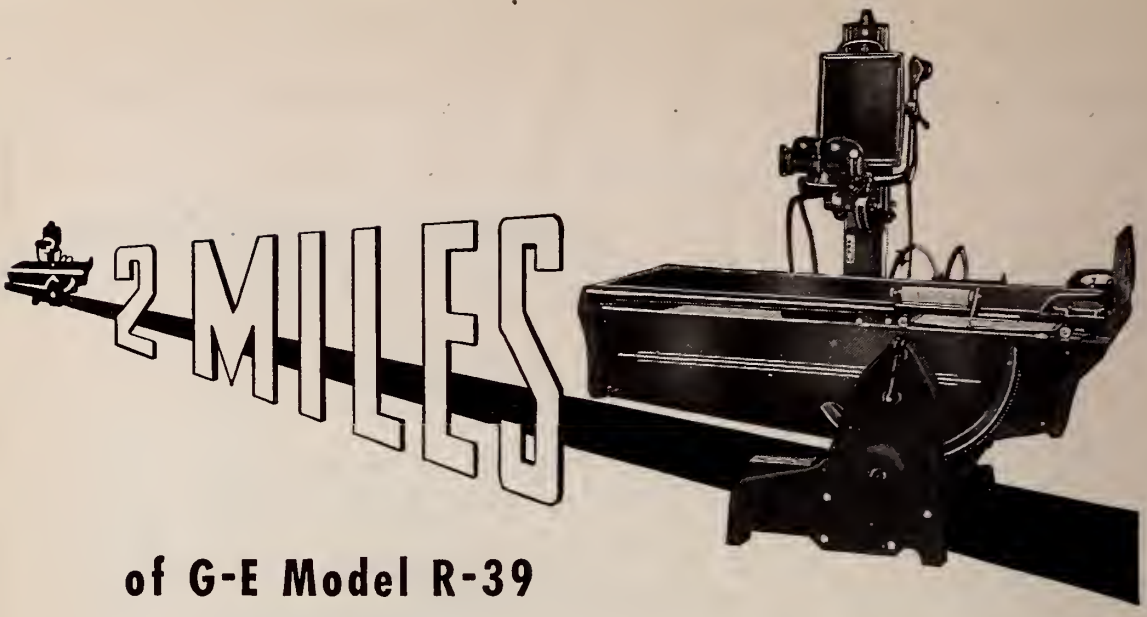
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1. Watson, B. P.: J. Clin. Endocrinology 4:571 (Dec.) 1944.

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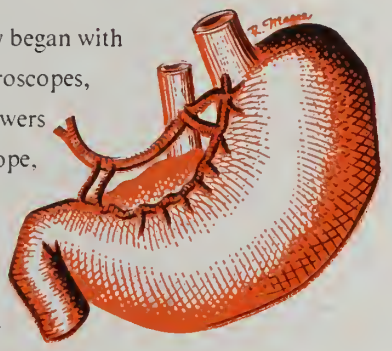
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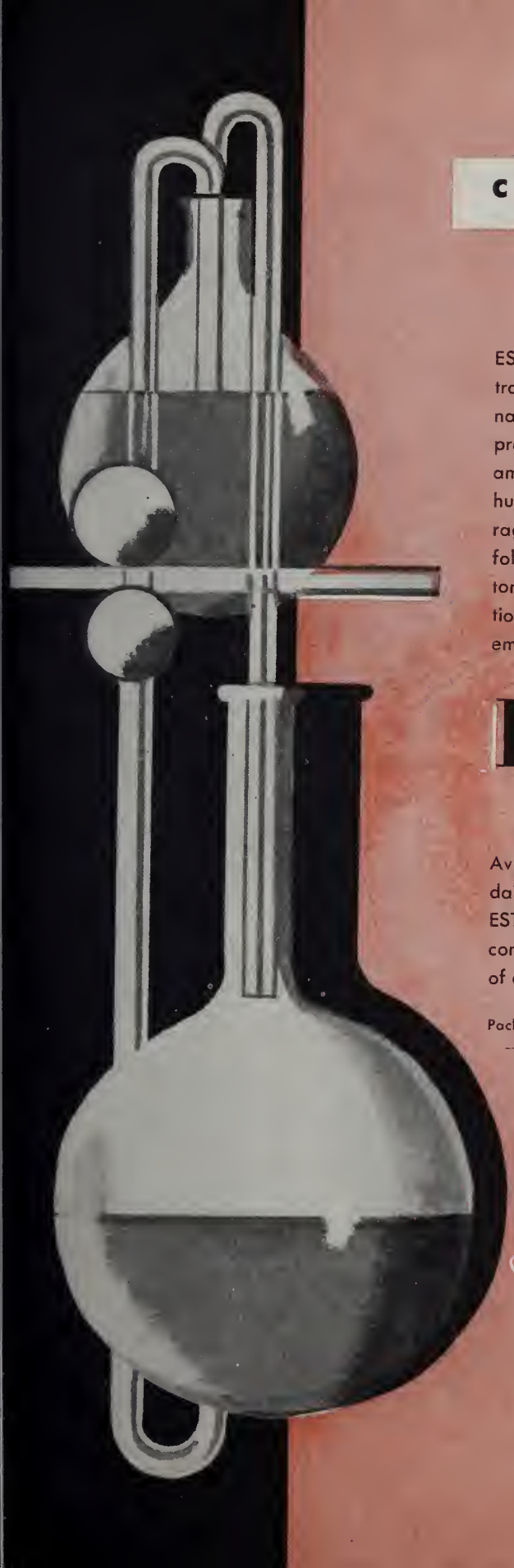
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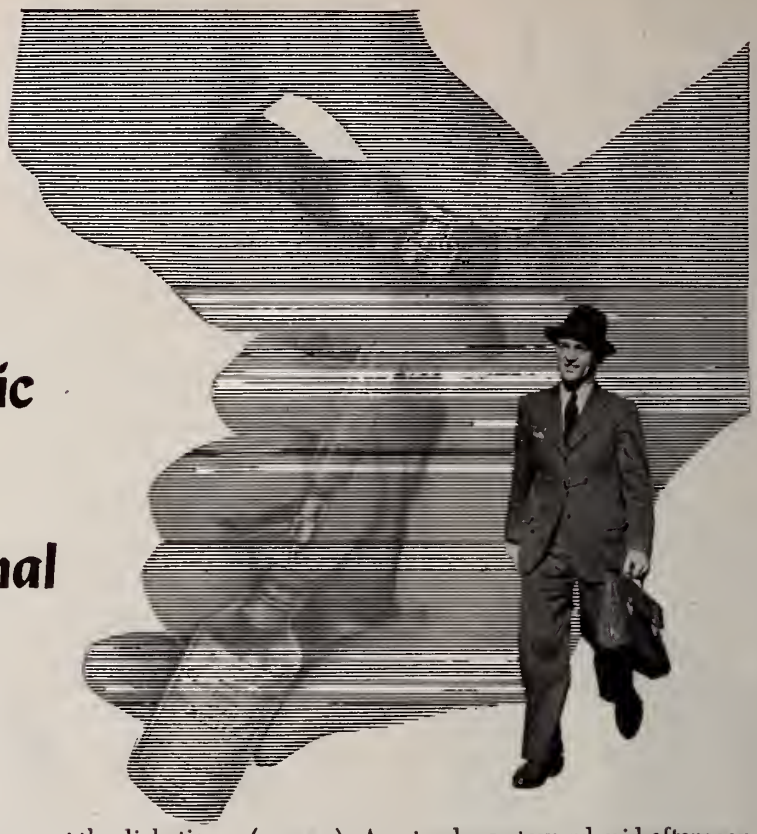
1. Bickers, W.: Am. J. Obst. & Gynec. 51:100, 1946.

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1. Bauman, L.: Bull. New Eng. M. Center 5:17 (Feb.) 1943.

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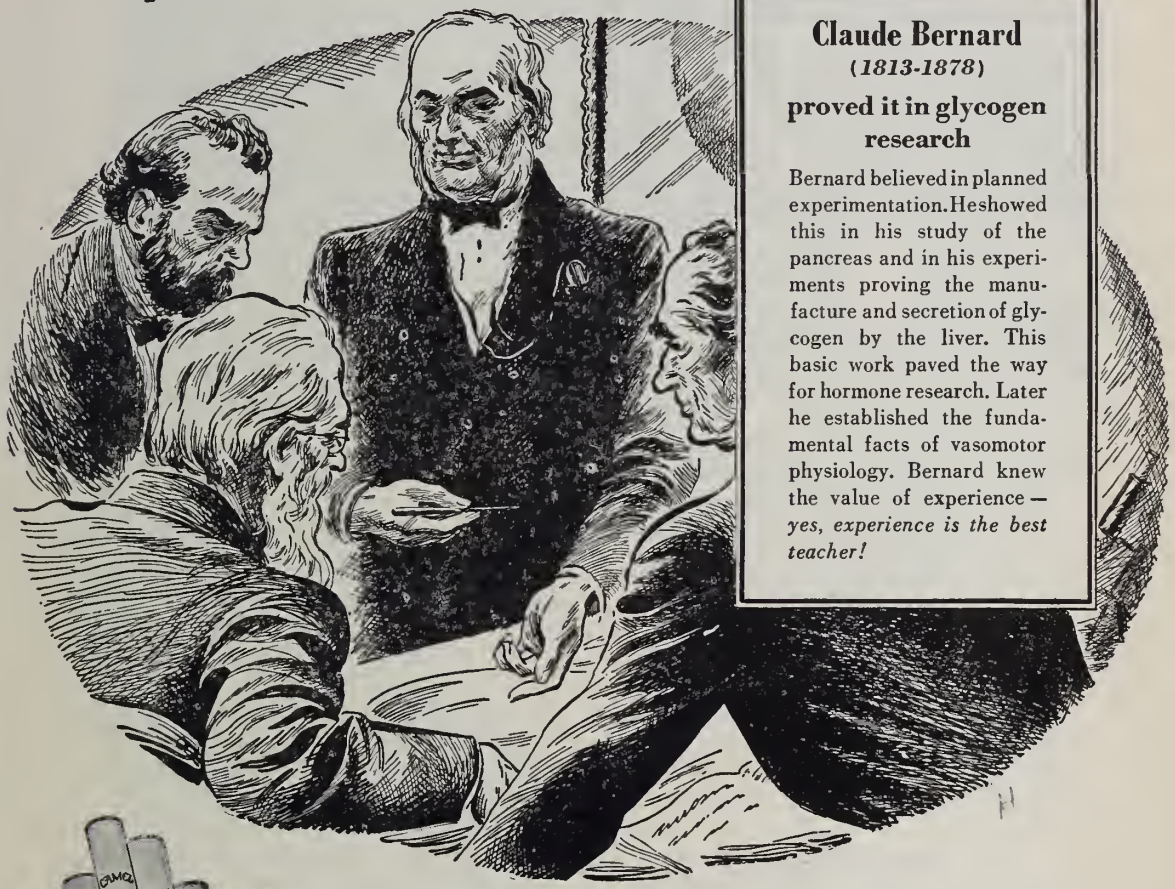
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1 National Research Council Bull. No. 109. 1943. pp. 18-21.

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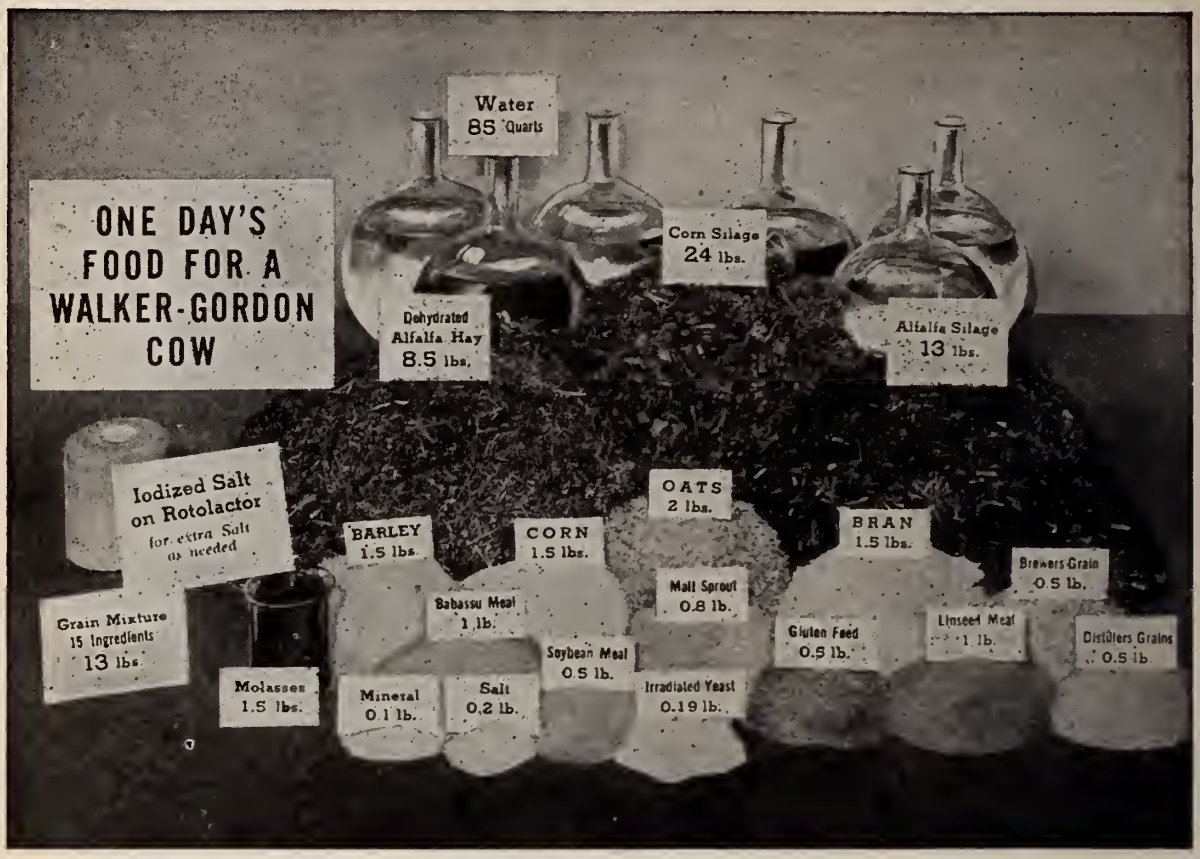
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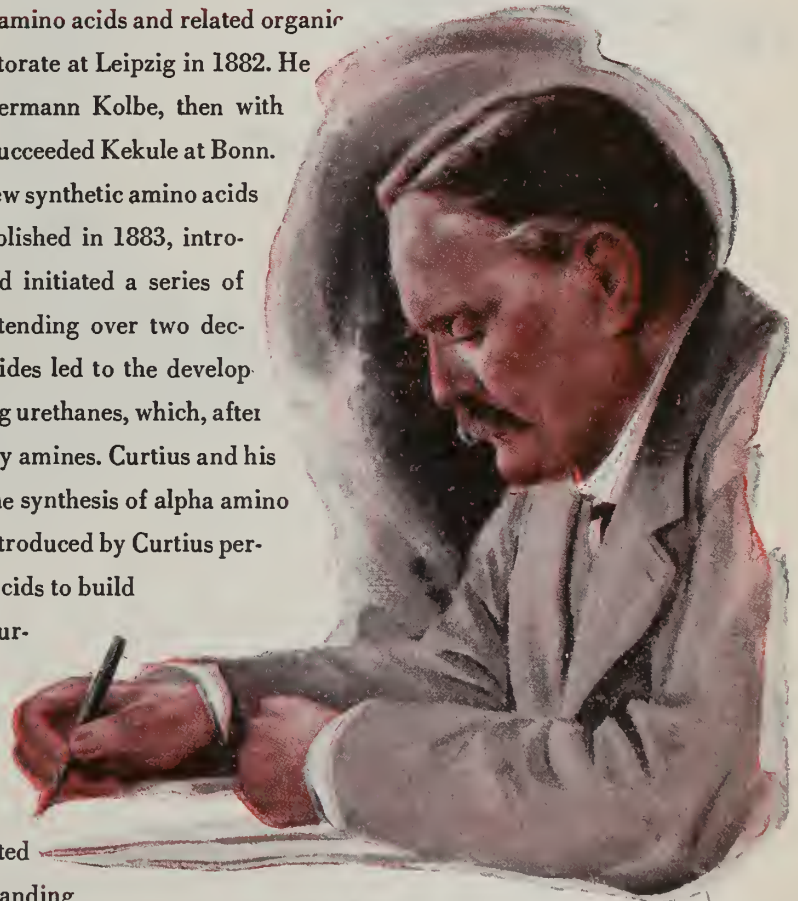
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12. DeJong, R. N. (1946), Further Observations on the Use of Tridione in the Control of Psychomotor Attacks, Am. J. Psychiatry, 103:162, September

Men and Amino Acids

This eminent investigator of amino acids and related organic compounds obtained his doctorate at Leipzig in 1882. He was associated first with Hermann Kolbe, then with Adolph Baeyer; in 1896 he succeeded Kekule at Bonn. His dissertation on several new synthetic amino acids related to hippuric acid, published in 1883, introduced diazoacetic esters, and initiated a series of systematic investigations extending over two decades. His work with acid azides led to the development of a method of preparing urethanes, which, after acid hydrolysis, yield primary amines. Curtius and his pupils evolved methods for the synthesis of alpha amino acids. Acid azide reactions introduced by Curtius permitted the linkage of amino acids to build polypeptides. As a teacher, Curtius attracted students from many countries. His elucidation of numerous problems associated with the chemistry of amino acids pointed the way to a clearer understanding of proteins and protein derivatives and their role in nutritional science.



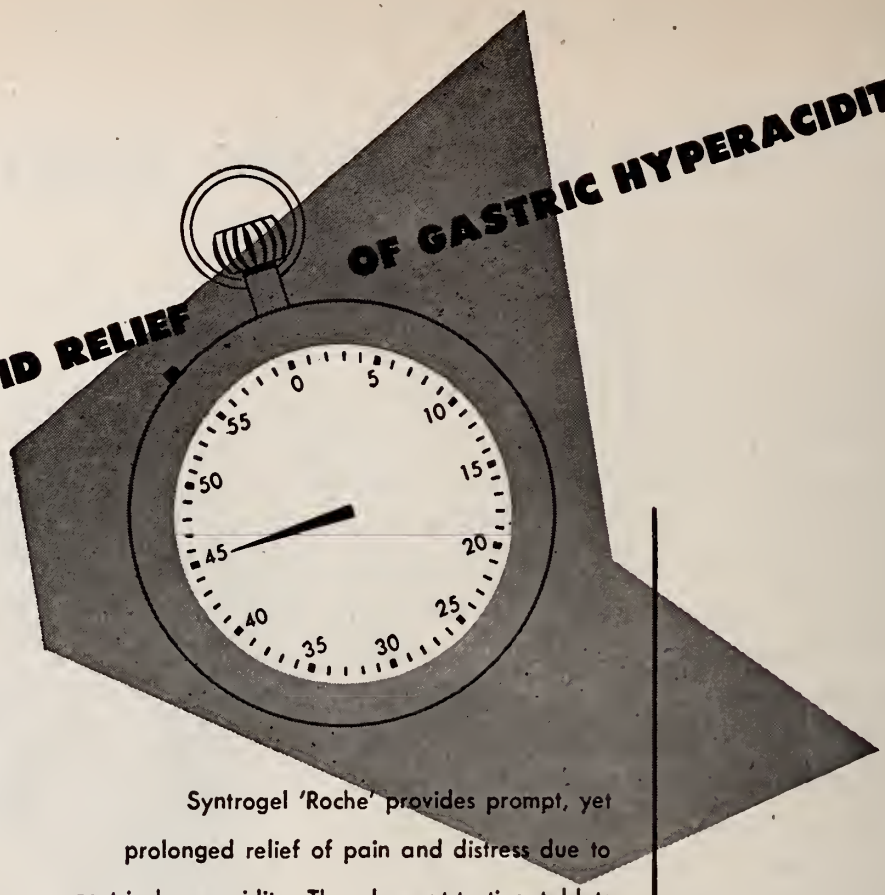
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In the correction of protein insufficiency, or in the maintenance of nitrogen balance, accumulating evidence substantiates the dictum that hydrolyzed protein substances should be employed *only* when oral feeding of protein foods is impossible or not feasible.

It has been shown experimentally[1] when hydrolysates of protein are injected at two different rates (1.0 and 1.5 mg. of nitrogen per Kg. of body weight per minute), the more rapid injection rate results in a higher excretion of both free amino acids and peptides. The authors ventured that even in the presence of a definite demand for protein replenishment, nitrogen excretion is mainly controlled by the kidney threshold.

In a recent survey, Ravdin[2] stated that "When oral feeding is used, whole foodstuffs should be given. There is no beneficence in feeding protein hydrolysates unless there is evidence of faulty digestion. Feeding of mixtures of polypeptides and amino acids may result in an absorption rate of amino acids which is more rapid than can be resynthesized by the liver, especially when the function of this organ is not normal."

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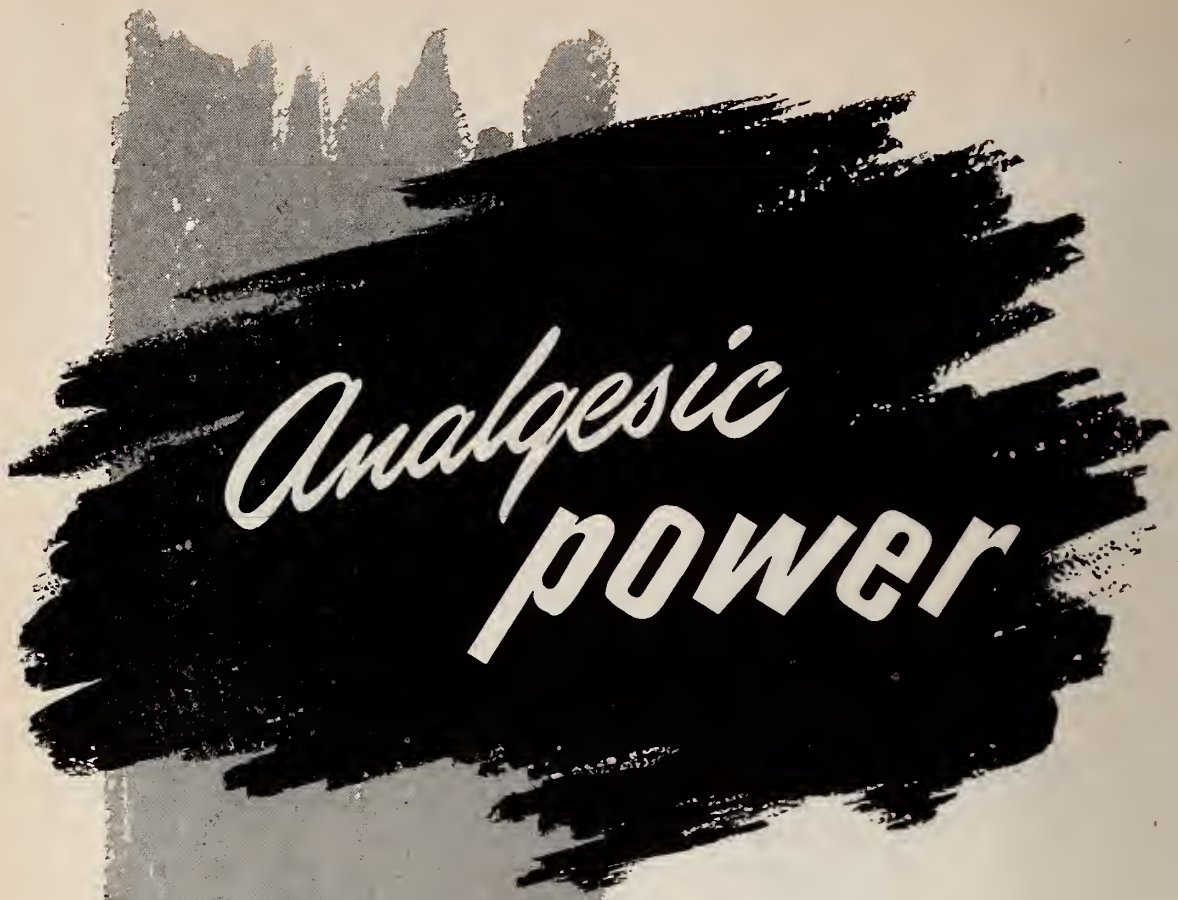
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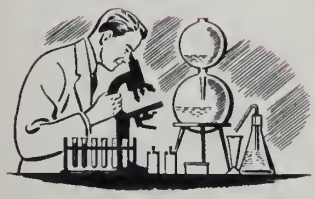


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A wide variety of dosage forms, including tablets, ampoules, and vaginal suppositories, is offered under the Lilly Label. They are readily available at your local retail pharmacy.



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Illustration by Arthur Sarnoff

"The 500-Mile Grind"

ALTHOUGH the annual Indianapolis Speedway race is a brilliant spectacle to the fans, it is a grueling test of men and machines. Each driver must pass a thorough physical examination before he is permitted on the track. In addition, a staff of physicians and assistants stand by in readiness for any emergency.

In most major sports and sporting events medical men make an important contribution. First of all, there must be assurance that every candidate is fit to withstand the physical rigors of the contest. Of equal importance are illnesses and injuries incidental to the sport which must be promptly and skillfully treated. Amateur and professional sports alike would be seriously handicapped were it not for the physician.

Behind the doctor are the personnel and resources of the ethical pharmaceutical manufacturer. Eli Lilly and Company maintains a staff of hundreds of specialized workers. Their function is to supplement the skill of the physician by providing him with reliable pharmaceutical and biological products.

VOLUME 44
NUMBER 5

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904
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COMMITTEE ON PUBLICATION
HENRY C. BARKHORN, M.D.,
Chairman.

HENRY A. DAVIDSON, M.D., Editor

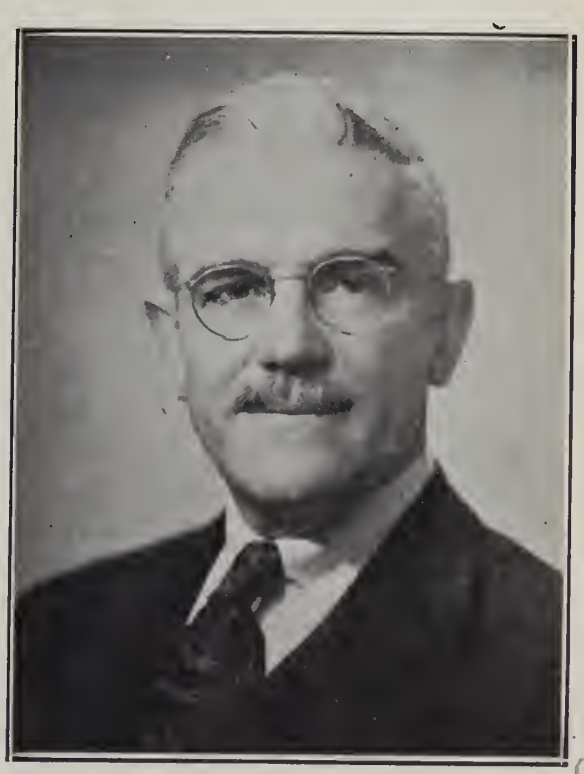
MIRIAM N. ARMSTRONG,
Assistant Editor

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Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

VOL. 44, No. 5 MAY, 1947 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

MEET ROYAL SCHAAF

Number one medical man in New Jersey this year is Royal A. Schaaf who last month was installed as the 155th President of The Medical Society of New Jersey. Dr. Schaaf takes the helm after an exceptionally rich period of training for the top medical leadership job in the state. He has served as president of the Academy of Medicine of Northern New Jersey, as president of the State Board of Medical Examiners, as president of the Essex County Medical Society, and, for many months during the past year, as acting president of The Medical Society of New Jersey. His experience has touched every facet of organizational work, much of it in the field of public relations. Since, for obvious reasons, the latter will be increasingly important in the year ahead, we are fortunate in having a man with such effective public relations experience to pilot the society this year.



Although Dr. Schaaf was born in Boone, Iowa, the Hawkeye State will get no credit for his rearing and education. At the age of three, he was bright enough to see the merits of New Jersey and moved here at that time. After completing his schooling in Newark and

South Orange, he matriculated at University and Bellevue Medical College in 1908. While he finished medical school in 1912, they would not give him his degree until the following year. It seems he was under twenty-one when he completed his medical school curriculum, and thus legally "an infant". He interned at Bellevue, and then, after one year of residency, opened an office in New York City. He soon closed this to enter the Army—that was the first World War—and after two years of active military service was mustered out during the summer of 1919. He then decided, fortunately for us, to return to his "home town" and established an office in Newark in September 1919.

On New Year's day 1917, he married Helen DeVore Thomas. He has two children, one son and one daughter. And two grandchildren, one to each. The son is a physician, now a resident at Massachusetts General Hospital. And the son-in-law is a physician, now a resident at Massachusetts General. With Dr. Schaaf, everything is always neatly balanced that way.

Dr. Schaaf brings to a focus the two prime qualities needed in organizational leadership. He is a good doctor and a good executive. He is an attending surgeon at three large hospitals in Essex County, but as his professional colleagues well know, he has never immured himself in the white-walled isolation of the operating room. He has always remained well at the front of the advancing tide of medical knowledge; and though vice-president of the Society of Surgeons of New Jersey, he is professionally at home with obstetricians and internists too. He confirms anew the tradition that you can't be a good medical society leader without being a good doctor too.

In The Medical Society of New Jersey, the President has never been an honorary figure-head. For more than a century now, the President has always set the organizational pace for the Society. The profession fares best when its leader combines dynamism with tact. And Royal Schaaf is an ideal exemplar of these two qualities which, among most of us, are seldom found in the same person. Indeed, as a glance at the picture shows, he even looks like a President.

Congratulations are due, not only to Royal Schaaf, but also to The Medical Society of New Jersey.

CANCER AND THE PRIVATE PRACTITIONER

During the past year great strides have been made in cancer control in New Jersey by the Medical Society in cooperation with the American Cancer Society.

It has been agreed that it is the responsibility of the physician to suggest and direct medical projects for cancer control. The money has been collected by the American Cancer Society, and we physicians have it available for appropriate medical projects.

We have a further responsibility in administering these monies. They must not be wasted on unsound projects.

To standardize a good program, *Cancer Control in New Jersey* was published as a guide both in the organization of new clinics of various types and the cost of equipment for them. These articles appeared in the September 1946 and February 1947 issues of The Journal of The Medical Society of New Jersey.

The Cancer Society and our Cancer Committee have been deluged with requests for financial aid for equipment. Many of these requests reflect poor insight into the cancer problem. Many have completely neglected the proper planning for the establishment of an effective organization. The mere purchase of equipment and therapeutic adjuncts is not the answer to the cancer problem. We need a proper organization to cooperate effectively with and assist the general practitioner.

Our only yardstick for approval of a project has been *"Will It Help the Cancer Patient?"* We do not intend to approve expenditures for general hospital equipment, for hospital libraries nor for medical social workers in numbers exceeding those who could effectively improve the lot of a cancer patient in a hospital. We intend to have a monthly report on work done in all clinics to which monies have been allocated. These results will be published in future issues of THE JOURNAL. Those asking for aid should produce tangible results because results attained will serve as a yardstick for future aid. Therefore, scrutinize your requests carefully, organize properly.

At a recent meeting, the Advisory Committee on Cancer Control and the Board of Trustees of the Medical Society voted against the establishment of the so-called "prevention" or "screening" clinics which are, in effect, health maintenance clinics, if the cost of services to the private patient is underwritten by the American Cancer Society. These patients rightfully belong to the general practitioner so long as he discharges his duty to the patient. Much criticism has been levelled against physicians by proponents of such plans. Some of the criticism is justified by the failure of some practitioners to take good histories and do complete physical examinations, particularly when a patient requests a complete examination to rule out cancer.

No problem as large as that of cancer can be solved unless we have the effective cooperation of all physicians, and especially the general practitioner. He will continue to see more cancer than all the clinics. It is up to the clinic to be ready to help him when help is needed.

This year cancer publicity is directed towards advising patients to consult their family physicians.

The Advisory Committee on Cancer Control and the Board of Trustees of the Medical Society are working for you. We ask you to help us in this by doing your part. Take a complete history; do a really meticulous physical examination. Satisfy the inquiries of your patients. Take a biopsy when you suspect cancer. Do not procrastinate. This is one of the most challenging projects ever facing the private medical practitioner.

A CENTURY OF THE NEW YORK ACADEMY

The New York Academy of Medicine is to be congratulated upon its one hundredth year of useful and forward-looking service to the people and physicians of the city of New York. It has lived up to its high standards of civic and social responsibilities with respect to the public health, the provision of accurate medical information, and its related program of professional and lay instruction.

Its magnificent reference library, housed in one of New York's outstanding edifices on Fifth avenue at 101st street, is among the finest in the country. Recently, a building extension has been contemplated to expand the library facilities, to provide exhibit halls, and to further the usefulness of the Academy to doctors and public alike.

The work of the Committee on Medicine and the Changing Order is a notable contribution to the advancement of the study of the social and environmental factors responsible for illness and mortality, and of the changes in methods of medical practice and medical education thought to be necessary before the full benefits of modern curative and preventive medicine can be made available to all the people.

The Medical Society of New Jersey extends sincere congratulations to the Academy on a century of notable public service.

—Reprinted from N. Y. State Journ. Med., April 15, 1947

ORIGINAL ARTICLES

THE CANCER PROGRAM IN NEW JERSEY

PART III. ESSENTIALS IN CARE OF THE CANCER PATIENT

Prepared by the Advisory Committee* on Cancer Control of
The Medical Society of New Jersey

Cancer is a public health and welfare program of increasing magnitude. It is, furthermore, an integral part of the whole problem of chronic illness. During the past two decades, mounting interest has been manifested in New Jersey in both problems—the cancer patient, and the chronically ill.

Recent studies[1] have dramatically brought to our attention the serious lack of proper facilities for the care of the cancer patient and for those suffering from chronic diseases. The need for furnishing such facilities is urgent. In addition to the medical and public health aspects, there are social and economic burdens associated with long periods of invalidism and disability which demand full consideration by the community.

LONGEVITY INCREASING DIFFICULTIES

Modern living conditions have to a great extent relieved the general population of the many dangers of infectious diseases; infant and child welfare movements have reduced child mortality rates; present public health practices are all conducive to prolonging the span of life of the general population. The life expectancy at birth which was 50 years in 1900 reached 65 years in 1945.

Long life, however, has not proved an unmitigated blessing to the majority of the population; a person rarely reaches the age of 65 without some signs or symptoms of chronic illness.

"CHRONIC NOT TO BE REGARDED AS INCURABLE"

Until recently the successful treatment of the cancer patient and the other chronic sick has been greatly hampered by the widespread confusion between the terms "chronic" and "incurable". "Incurable" has a fatalistic sound which spells discouragement to the patient and implies defeat to medicine and modern science.

Many patients suffering from cancer and other chronic illnesses are not incurable but do require a long period of treatment before they can be rehabilitated. Other patients are victims of a lingering, slowly-progressive illness which requires constant care and attention. Still others have a fairly constant state of illness which requires careful supervision if exacerbation is to be avoided. All of these patients require extensive medical, clinical and hospital facilities.

ESSENTIAL ELEMENTS OF CANCER CARE PROGRAM

The essential elements of a cancer care program can be outlined as follows:

1. *Detection of cancer signs at the earliest moment and ready availability of adequate medical and surgical treatment (private physician, cancer clinic, hospital, etc.)*
2. *Community care of cancer patients in their own homes.*
3. *Hospital and institutional facilities for the care of cancer in-patients.*

THE PRIVATE PHYSICIAN

In the activities of the private physician are seen the greatest possibilities for the early detection of cancer and for the effective application of remediable measures if such are indicated. He too has unrivaled opportunities to make effective a program of health maintenance examinations which are a part of the cancer control and prevention movement.

* This committee consists of Doctors W. O. Wuester (Chairman), O. R. Holters, J. I. Echikson, H. W. Jack, J. H. Kler, T. B. Lee, W J. Marquis and Leonid S. Snegireff. Emil Frankel is consultant to the Committee.

1. *Report on Chronic Diseases in New Jersey* and other studies made by the New Jersey Department of Institutions and Agencies. Similar surveys have also been made by the N. J. State Department of Economic Development.

The idea is gaining momentum among New Jersey physicians to make complete physical examinations in their offices upon previous appointment allowing the time that such medically approved "health inventories" require.

CANCER CLINICS

Cancer clinics are being enthusiastically received by the local medical profession. They represent our most effective means of combating cancer by bringing into close cooperation the general practitioner, the surgeon, the radiologist, the pathologist and other specialists.

Patients can be treated at decentralized cancer facilities more promptly, more efficiently and less expensively than would be the case if they were required to travel long distances. In most instances, when treatment facilities are in close proximity, the patient is ambulatory and can follow, at least to some extent, his usual line of work. This avoids total economic loss to his family. Hospitalization should then be reserved for certain special treatment.

Three types of cancer clinics[2] are recommended:

A. A cancer clinic which functions six days a week under constant supervision of a trained oncologist. This type of clinic treats cancer in all its phases.

B. A cancer clinic where the interested physicians on the existing staff play the largest part in the work. This type of clinic calls for a consultant whose function would be to aid in the organization of the clinic and development of its services.

C. A diagnostic or screening clinic which may eventually develop into a full grown and well organized complete clinic. The clinic could be a department in the regular outpatient clinic of the hospital.

CANCER IN-PATIENTS IN GENERAL HOSPITALS

The general hospital occupies an important place in the total program for the care of the cancer patient and the long-term patient generally. The type and quality of care required by patients suffering from chronic illness is practically the same as that required by the acutely ill patient. It may differ only in the extent of special services needed and the longer hospital stay required.

General hospitals are, with rare exceptions, willing to admit, for treatment, patients suffering from acute exacerbations of chronic disease; but they consider that their obligation does not extend beyond the point when active treatment has ceased to be demonstrably helpful in the improvement of the underlying pathology.

Under the provisions of the recently enacted Federal Hospital Survey and Construction Act it is recommended that "insofar as practical, chronic disease hospitals should be units of general hospitals, because as parts of general hospitals they will go further to insure active treatment of chronic disease patients and offer more hope of improvement for remediable cases."

An active social service department should be functioning in the general hospital in close cooperation with community nursing organizations to help the cancer and other long-term patient about to be discharged from the hospital to meet those personal and social situations which have a bearing on his particular health problem, and to facilitate his readjustment in the community.

CARE OF PATIENTS IN THEIR HOMES

Home care may precede or follow hospital care, or may in itself be adequate for many types of chronically ill patients if home conditions are favorable, and if home activities can be so regulated that the presence of the patient will not disturb the family life.

If an individual suffering from cancer or other chronic disease is indigent or medically indigent, the patient and his family are not financially able to provide such home care. Then, the community has a moral responsibility to provide necessary medical and nursing care.

The services of nurses available through the Visiting Nurse Associations and kindred organizations can be utilized most advantageously in the nursing care of the cancer patient and the other long-term patients.

2. For details see Part I. Diagnostic and Therapeutic Cancer Clinics—The Cancer Program in New Jersey, September, 1946, issue of this JOURNAL.

A significant development in this connection is the agreement that has been reached between the Mercer County Chapter of the American Cancer Society and the Visiting Nurse Association of Trenton to work out cooperative services "since both are deeply interested in promoting early diagnosis and treatment of cancer."

The Visiting Nurse Association has agreed to provide the service of a well qualified public health nurse whose duties include: (a) Attendance at and responsibility for nursing care at the tumor clinics to be held at the out-patient departments of the three local general hospitals; (b) Arranging for the appropriate follow-up of patients attending these clinics; (c) Supervision of the Visiting Nurse Association's nursing services to cancer patients. These services are available to patients from the tumor clinics and also to patients of private physicians where the latter approve; and (d) Supervision of the record keeping work of the cancer clinics, including recording of the proceedings of staff conferences, keeping records of individual patients, assemblying statistics growing out of the general activities of cancer clinic work and of follow-up work of discharged cancer patients.

The consultant nurse will keep the other staff nurses aware of new developments in the nursing care of cancer cases and will advise with each nurse on the measures ordered by the physician as appropriate for each individual patient. When indicated she will accompany the staff nurse into a patient's home to demonstrate special procedures.

The consultant nurse will carry a small geographic district of her own for generalized nursing visits, and will herself give bedside care to cancer patients living within her district; and she will assist in the collection and analysis of statistics on cancer patients under the care of the Visiting Nurse Association.

To make home care of long-term patients more readily feasible and to reinforce the work of the visiting nurse, a corps of housekeeping aides should be available. These aides can assist in the housework of the chronically ill who are not strong enough to do their own without such assistance. Help of this kind adds greatly to the comfort and happiness of semi-invalids living by themselves.

It is important, therefore, that the competent health and welfare organizations—both public and private—in the various New Jersey communities unite to develop a training program for housekeeping aides which will give them scope for effective functioning.

THE NURSING HOME

Nursing homes of high standards fill a real need in the care of the chronically ill and their continuous development is an important factor in providing the needed facilities for the growing number of cancer and other chronic disease patients.

A nursing home is defined by New Jersey law as a "home for care, treatment, and nursing of persons who are ill with diseases or who are crippled, infirm, or in any way afflicted". Such a home becomes subject to license if two or more persons are cared for at one time, and the power of license and supervision is vested in the New Jersey State Department of Institutions and Agencies.

The licensed nursing home provides the opportunity for service to many types of patients from varied social and economic settings. Most homes are small enough to permit a certain amount of congeniality among the patients and to make possible individualized care.

With greater frequency the nursing home is being called upon to care for the chronic patient, the patient who needs long-term care for an illness from which there is little hope of recovery but which does not require the type of service afforded in general hospitals to patients with acute illnesses.

THE WELFARE HOUSE

The county welfare house, equipped for infirmary care of the sick, is an indispensable link in the chain of institutions caring for the indigent cancer patient and the chronically ill. These county welfare houses (as well as the municipal almshouses) are among the oldest of our welfare institutions, and are subject to supervision by the Department of Institutions and Agencies. They have come to realize that the majority of persons admitted for care are

essentially the chronically ill needing active medical treatment.

In many instances the so-called terminal cancer patient, especially if he is indigent, may find the welfare house suited to his need. It is important, therefore, that both the appropriate medical and nursing services as well as facilities are directly available.

A peculiar responsibility rests upon the county officials in charge of public welfare houses to recognize the present-day needs of the long-term patient and make such changes in facilities, equipment, personnel, and management as may be necessary to meet their special requirements under the guidance of the New Jersey State Department of Institutions and Agencies.

There rests a further responsibility upon the various governmental bodies in New Jersey to see to it that in planning for the care of the long-term patient in the future only the most modern and approved facilities and methods be adopted.

CHRONIC DISEASE HOSPITAL

If it seems advisable to establish a chronic disease hospital, it should be closely tied to a general hospital and become an administrative part of it. This is strongly recommended in the Federal Hospital Survey and Construction Act.

The hospital for chronic diseases is a distinct institution that combines for the chronically ill the services of a general hospital and a nursing home on a large scale. It is one step in advance of a welfare house. The latter has developed along lines made necessary by the patients already under care, while the hospital for chronic diseases has been designed from the beginning to give to the chronically ill every service for their comfort, happiness, and restoration to health insofar as possible.

Every phase of diagnosis and treatment, with special emphasis on the physiotherapy and electrotherapy, X-ray, basal metabolism and dental departments, should be covered.

There should be a hospital section for diagnosis and treatment and a custodial section for domiciliary care. Special provision should be made for (a) those needing active medical care for diagnosis and treatment (b) those needing skilled nursing care and (c) those needing custodial care only.

The chronic disease hospital should have a constructive program of diversional and curative work and a social service department able to render individualized social care work with the chronic patient.

Since the less populous counties may lack the financial resources to establish such hospitals, it is recommended that district hospitals for chronic disease be considered which would take care of cancer and other long-term patients from several counties.

It would seem inadvisable to establish separate large cancer hospitals removed at considerable distances from the patient's home which would come to assume the aspects of hospitals for "incurables".

Commissioner Sanford Bates of the New Jersey State Department of Institutions and Agencies says: "The development of some regional or county institutions for the chronic sick of all ages is a compelling obligation in New Jersey today. No one wishes to advocate the return of the almshouse but an institution of a new character emphasizing medical care for the increasing number of persons who need long-term care and are unable to care for themselves due to chronic illness is an immediate necessity."

COMMUNITY RESPONSIBILITY FOR THE CANCER AND LONG-TERM PATIENT

In the past, care of the long-term patient has been left largely to private philanthropy, but changing urban conditions, unavailability of employment for those in middle and old age, the decrease in the size of families (which places the financial and social responsibility of the aged and ill on one or two children with their own minor dependents to support), are emphasizing the necessity of community responsibility in this field.

New Jersey municipalities and counties have the responsibility of adapting present resources and of developing new ones to offer adequate all-round care to the chronically ill. The movement toward the local program must come from

within and be supported by individuals and agencies — public and private — dealing with chronics. Public health officers and municipal and county officials should assist in formulating a public aid plan.

OUTLOOK FOR THE CANCER AND OTHER LONG-TERM PATIENT

In surveying the situation today, it is evident that New Jersey is on the road toward recognition of the special needs of the cancer and other long-term patient just as we have previously recognized the special needs of the mentally ill, the epileptic and the tuberculous.

Slowly the various health and welfare organizations are recognizing the care of the chronically ill as their special function and are beginning to adjust their programs and facilities to meet the needs of these patients.

It may be true that the general public has as yet no deep understanding of the significance of chronic illness. A definite and cooperative program of public education, therefore, is indicated so that the extent and urgency of the problem will be fully recognized and the facilities fundamental to a comprehensive program of care and prevention will be made available.

PENICILLIN FACTS AND RUMORS

Recent articles in periodicals of wide circulation have created unwarranted fears in the minds of the public concerning the value of penicillin and other new remedies.

Physicans should be in a positon to give their patients the facts concerning penicillin and to allay any doubts or fears created by these publications. Briefly, the facts concerning the latest developments in penicillin therapy are as follows:

1. Commercial penicillin has consisted of varying mixtures of one or more of the five known fractions, F, G, X, K and dihydro F.

2. Penicillin K is apparently rapidly destroyed or eliminated in the body, and therapeutic levels are not achieved or maintained in the body fluids following ordinary doses.

3. Commercial penicillin now available is predominantly penicillin G, which is effective although some of the penicillin produced in 1945 may have had relatively less G and more K than previous or subsequent batches.

4. As far as facts are available, penicillins F and X are as active clinically as penicillin G. Further research will be necessary to define their usefulness with preciseness.

5. Since precise methods are not available for the routine determination of the quantities of each fraction in each batch of penicillin, the National Research Council has recommended increased dosage of penicillin as a safety precaution, particularly in the treatment of syphilis, in which the end result of therapy cannot be evaluated for a long time.

6. Although bacteria have been made resistant to penicillin in the test tube, development of clinical resistance has not become a problem. Such an eventuality may be prevented, in part, by giving adequate and not minimum doses of penicillin.

7. All penicillin and penicillin pharmaceuticals currently on the market have been examined and certified as to safety and efficacy by the United States Food and Drug Administration.

8. It is possible that natural or synthetic variations of the penicillin molecule will result in the development of a clinically better penicillin. None better than penicillin G is now available.

While it is realized that the rapid developments now being made in therapeutics make it increasingly difficult for busy physicians to read and evaluate the many scientific articles appearing in hundreds of periodicals, the physician can keep himself informed of the more important developments through a study of the Reports of the Council on Pharmacy and Chemistry. Furthermore, the Council office and its personnel are always ready to answer inquiries and furnish information on drugs and therapeutic agents. Physicians, by using this service, can allay the fears of their patients who have come to doubt the efficacy of penicillin even when properly used.—From J. A. M. A., Aug. 24, 1946.

REHABILITATION SERVICE IN NEW JERSEY

Henry A. Brodkin,* M.D., Newark, N. J.

Physicians, as individuals, often lack interest in social, economic and governmental affairs and agencies which concern them directly and indirectly through their patients. In our own state, it is obvious, that too few private practioners know about the work of N. J. Rehabilitation Commission, their relation to this service, as well as their responsibilities to the physically handicapped persons of the state. Every doctor in New Jersey should know the basic principles of the State's Rehabilitation Act and the Federal Vocational Rehabilitation Act. These acts provide rehabilitation service to persons, who, because of a disability resulting from accident or disease, have an employment handicap.

New Jersey was one of the first states in the union to enact a law for rehabilitating the physically handicapped. In 1919, the legislature created the Rehabilitation Commission. The Commission consists of the Commissioners of Labor, Education and Institutions and Agencies and five other members appointed by the Governor. One is a representative of employers of labor, one representative of organized labor, and the others, (one of whom is a woman) are chosen because of special interest and knowledge of rehabilitation and the care of crippled children. The present Chairman-Director is the Commissioner of Labor, Harry C. Harper.

Its major objective is to restore or improve the working ability of disabled people through vocational rehabilitation and physical restoration. The program is assisted financially through the Federal Office of Vocational Rehabilitation. "It provides medical examination, necessary medical, surgical, psychiatric and hospital services, necessary prosthetic devices such as artificial arms and legs, hearing aids and braces, individual counseling and guidance; vocational training in schools, on the job, by correspondence or tutors, placement assistance on the right job, job-follow-up to make sure the worker is in a suitable assignment; necessary tools, equipment, licenses, and even maintenance and transportation during rehabilitation."

All employable men and women of working age with substantial job handicaps in the form of physical or mental impairment are eligible for this assistance. Such services are available not only to those with obvious disabilities (such as amputees, paralytics, spastics, and the blind) but also for those unseen handicaps such as emotional disabilities, deafness, tuberculosis and heart disease. To be eligible a man or woman must be of working age, require economic help, have a substantial job handicap because of physical or mental disability and have a reasonably good chance of becoming employable or securing a more suitable job through the rehabilitation service.

The basic function of the Rehabilitation Commission is to provide physical restoration, counseling, training and placement. Each applicant is interviewed by a counselor assigned to his locality. He obtains a thorough knowledge of the client's circumstances, problems, aptitudes and ability. It is necessary in cooperation with the client to map out a comprehensive plan for his or her rehabilitation; for the client to see clearly how he or she can overcome the handicap, and achieve a worthwhile future. After this preliminary plan is approved, the client is requested to have a general physical examination. The Commission pays $5.00 for this examination. It is desired to have this done by the client's family doctor because he should be most interested in the successful outcome of the rehabilitation program of his patient. He also would become a valuable adviser in recommending any additional professional consultation or diagnostic procedure to determine the vocation that would properly fit the client within the limits of his handicap. Unfortunately, this has not been very successful because physicians are loathe to fill out the form and fail to give an adequate prognosis. They have not grasped the purpose of the examination and do not adequately describe the physical defect or make

* Chief Medical Director Workmen's Compensation Bureau.

the proper recommendation for improving the physical handicap. It was found that about two-thirds of the examination reports were worthless for these reasons. Some of the physicians who have had experience and knowledge of the rehabilitation service have given very satisfactory reports.

The medical aim of the program is to bring the clients to the greatest degree of physical capacity. This may be accomplished in several ways. After the general physical examination it may be found necessary to seek consultation with a specialist or perform diagnostic tests or hospitalize the client to definitely determine his physical status. If an operation or treatment is necessary, the Commission will pay the operative fee, the cost of hospitalization, nursing and convalescent care, if necessary, according to its fee schedule (which is similar to that of the Veterans Administration). The Commission has contracted with most of the recognized hospitals to pay an approved per diem rate. Up to ten days' hospitalization is authorized for diagnostic purposes and up to ninety days for treatment of a physical defect. In addition, if an artificial limb or other orthopedic or prosthetic appliance is needed, this is provided for by the Commission subject to the approval of the client and the Medical Consultant.

The Commission also provides training in a vocation or profession within the maximum limits of the physical and mental capacity of the client. If necessary, it will contribute to the financial support of the client during the period of training. This training is provided either to prepare the handicapped person for a job or to train him for a better job. The training must be directed toward a definite job goal.

The fourth and final service is placement. Many industries during the war learned the value of employing physically handicapped personnel. They found them, as a class, more efficient, more safety-minded, and less guilty of absenteeism. Cognizant of their physical handicap, these employees are more anxious to please and prove that they can equal the output of their normal fellow employees.

A case is not closed until it is definitely established that the client is not eligible or feasible for rehabilitation or until he is happily functioning at a satisfactory job and has become self-sufficient.

New Jersey during the past 25 years has been in the forefront of programs for the rehabilitation of the handicapped. However, the work was originally limited in its scope and its clients were almost entirely orthopedic cases. Following the adoption of the Barden-LaFollette Act (the Federal Vocational Rehabilitation Act of July 6, 1943) the program was expanded to include all physically and some types of mentally handicapped people. During the existence of state rehabilitation programs prior to the enactment of the federal law, only 210,000 out of an estimated 2,000,000 needing this service received it. This amounted to about 9000 cases per year. Since the federal law was passed (in 1943) the service has increased 500 per cent, and for the coming year the federal office is trying to increase this figure threefold. Last year some 44,000 persons were rehabilitated at an average cost of $300 per case. Of this number, 18 per cent had never been employed and 79 per cent were not employed at the time they applied for rehabilitation. Their average monthly income increased from $24 a month (before they were rehabilitated) to $147 after placement. Many were on public relief assistance at an average cost to the taxpayer of $500 per year.

The average increase in annual earnings (average $1764) of these people has returned to the government in income taxes more than the cost of rehabilitating them.

During World War II there were 17,000 major amputations among the armed forces. During the same period there were 120,000 amputations among the civilians. The number of civilians with major amputations is conservatively estimated at 250,000 and is reported to be increasing at the rate of 25,000 per year. These figures graphically show the magnitude of the problem without taking into consideration the millions handicapped by other conditions such as heart disease, tuberculosis, arthritis, defective hearing, spasticity, epilepsy, blindness, etc.

Of the 44,000 persons who were rehabilitated and placed in positions, 2640 of them were in New Jersey. This is merely scratching the surface, for it has been estimated that there are about twenty million people in the United States who require some rehabilitation service.

Why do not more handicapped people with orthopedic, pulmonary, cardiac, neurologic and ophthalmologic defects receive the benefit of rehabilitation service? First, the profession as a whole, as well as the individual physician is not aware of the service available through the Rehabilitation Commission. Second, the social service and philanthropic agencies throughout the state that are engaged in certain phases of rehabilitation are not sufficiently coordinated to work through the Rehabilitation Commission.

1060 Broad Street

QUINIDINE — A DANGEROUS ALLY

A. D. DENNISON, JR., M.D., Maplewood, N. J.

It has often been said that, in England, to the sporting heart of the English physician an accurate diagnosis is all important. In Britain, the diagnostician or internist ranks higher than the surgeon; whereas in the United States the extensive promotional activities of the drug industry, combined with our own native desire for quick results, have made us all want to become therapeutic geniuses. British texts devote much space to signs, symptoms and differential diagnosis, but give very little attention to treatment. Our medical literature is replete with many volumes solely devoted to therapy and the standard works give much space to a legion of treatments,—sound and unsound.

Use of medication for an isolated symptom, with neglect or ignorance of the fundamental diagnosis, and with little or no understanding of the pharmacologic and physiologic principles is fraught with danger. With no other drug is this more true than with quinidine. Some physicians never use it and call it a dangerous remedy; others prescribe it blindly unaware of its dangers, indications and contraindications; and some use it judiciously with calm certainty of what its requirements are.

The basic and well understood pharmacologic actions of quinidine, omitting controversial points still under experimental study are fourfold:—

1. It increases the refractory period of heart muscle.
2. It increases the conduction time of heart muscle, thus slowing the conductivity of any impulse.
3. It depresses conduction in the junctional tissues.
4. It brings about a decrease in contraction and irritability.

Thus, to the electrocardiographer, with these facts in mind, the following changes may be noted in the EKG.

1. Change in the form or an increase in the duration of P.
2. Prolongation of the P-R interval due to an increase in the auriculo-ventricular conduction time.
3. Widening of QRS due to prolongation of the intraventricular conduction time. This occurs with large doses.
4. The Q-T duration is prolonged.
5. Decrease in the amplitude of the T wave in all leads. This is the earliest and most constant effect upon the ventricular complex.
6. Conversion of auricular fibrillation into auricular flutter or normal rhythm.
7. Conversion of auricular flutter to normal rhythm.
8. Reduction in the frequency of premature beats, no matter where the source may be.

It is certainly paradoxical that in toxic doses, certain cardiac drugs can produce many of the irregularities they are called upon to abolish in therapeutic doses. Quinidine in overdosage may produce auriculo-ventricular block, extrasystoles, paroxysmal tachycardia, cardiac standstill from auricular standstill, intraventricular block and ventricular fibrillation. The production of ventricular fibrillation may be explained by a circus movement in the ventricle. Certainly quinidine's use in the prevention or abolition of extrasystoles and ventricular paroxysmal tachycardia is well known. Papaverine, a cardiac drug, fast gaining in

popularity can both produce and abolish ventricular premature contractions (Elek and Katz [1]).

Digitalis has many paradoxical effects. Since these are well known, ominous difficulties are infrequently encountered. But with quinidine one may promote an exitus if the indications, contraindications, quirks and vagaries are not well understood. One problem is, that without the electrocardiogram, it is often difficult to detect trouble. The general symptoms of quinidine toxicity are mainly those of cinchonism: marked tinnitus, deafness, urticaria, nausea, vomiting, diarrhea and very rapid heart action. This tachycardia is due to the fact that quinidine blocks the vagus just as atropine does. It need cause no concern unless the rate rises above 140; then an arrhythmia such as a ventricular paroxysmal tachycardia should be suspected, and the drug discontinued. These exceptions reveal the need for close supervision and electrocardiographic control when one is using large dosages to effect a profound change in the heart rhythm.

Some definite contraindications to the use of quinidine may be listed as follows:—

1. *Idiosyncrasy to the drug*—this is the basis for the use of the original test dose.

2. *History of embolism* — sometimes this vascular accident has been overemphasized as the natural consequence of several forms of heart disease without the use of quinidine is embolic phenomenon. The very interesting paper by White and Blumgart [2] somewhat lessened the fear of using quinidine if emboli are, or have been present.

3. *Heart block* of any type-sinoauricular, auriculo-ventricular, bundle branch block, arborization block, partial or complete block.

4. *Old age.*

5. *Long standing congestive heart failure.*

6. *Cardiac enlargement* of any great magnitude.

7. *Mitral stenosis* indicates caution in the use of quinidine.

The conservative attitude towards quinidine in congestive heart failure (with hypertrophy and dilatation) is based on the well supported suspicion that these patients have intracardiac thrombi.

Indications for the use of quinidine are not many. There are a number of borderline indications which should require cardiac consultation before starting the drug. In these cases electrocardiographic control is desirable. The accepted indications are:—

1. *Auricular fibrillation* of less than three month's duration.

2. *Paroxysmal ventricular tachycardia.*— Many of the contraindications are swept away in the presence of a persistent tachycardia of this type, associated with acute myocardial infarction, and fast resulting in circulatory collapse.

3. *Prevention and treatment of episodes of auricular paroxysmal tachycardia.* As there are many other preliminary effective measures that can be used, quinidine is not commonly recommended.

4. *Abolition and prevention of extrasystoles,* particularly those arising in the auricle.

5. *Prophylactically in coronary thrombosis* to prevent the awesome ventricular paroxysmal tachycardia and ventricular fibrillation. This indication has not received widespread confirmation, and it seems best to be sure first that there is no conduction defect revealed in the electrocardiogram. Secondly, it is reasonable to withhold the drug until one observes frequent showers of ventricular extrasystoles, the forerunner of the other two arrhythmias.

6. *Occasionally in auricular flutter.*

Quinidine should rarely, if ever, be given intravenously. Oral administration usually suffices. In auricular fibrillation, one feels better if there is no auricular enlargement by fluoroscopy. And it should be added that the absence of F waves in the electrocardiogram suggest poor results but when coarse aricular waves are seen, the conversion to a normal sinus rhythm is easier.

601 Ridgewood Road

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7. White: Heart Disease, 3rd Edition:894, MacMillan.
8. Best and Taylor: Physiologic Basis of Medical Practice, 4th Edition:201, Williams & Wilkins.

STATE ACTIVITIES

TRUSTEES' MEETING
March 16, 1947

A regular meeting of the Board of Trustees was held on Sunday, March 16, 1947, at 1:00 p. m., State Society Headquarters, Trenton. Present were: Doctors Crowe, chairman, Lance, Sica, Hawkes, Coleman, Johnsen, Hornberger, Dodd, Green, Young, Costello, Schaaf, Stahl, Lee and Fithian. Also present upon invitation were Doctors Allman, Scott, Davidson and Barkhorn.

REPORT OF WELFARE COMMITTEE

Public Health

1. In accordance with the recommendation of the New Jersey Fellows of the American Academy of Pediatrics and the Child Health Committee of The Medical Society of New Jersey, all ward new born infants in New Jersey Hospitals should be the joint responsibility of the Pediatric and Obstetric services; or the sole responsibility of the Pediatric service, if such service is available. It is requested that a copy of this recommendation be forwarded to all New Jersey Hospitals.

The above recommendation was approved.

2. Relative to an established policy of physicians performing services for the Crippled Children Commission on a voluntary basis, the Committee feels that conditions have changed and that arrangements should be made for paying fees to physicians treating indigent children under the Crippled Children Commission, and not as an honorarium or annual fee. (The Welfare Committee requests the Trustees to take appropriate action.)

The following committee of the Board of Trustees was appointed to study the problem, with power to act: Dr. Elton W. Lance, Chairman; Dr. L. Samuel Sica, and Dr. Joseph G. Coleman.

3. That a policy of expansion and development of psychiatric facilities in general hospitals in New Jersey be encouraged, and that this be called to the attention of each general hospital in the state.

The above recommendation was approved.

4. Whereas, it has been long recognized that there is a high incidence of tuberculosis in general hospitals and other non-tuberculous hospitals, and that this has been recognized by the American Hospital Association, the United States Public Health Service, and the National Tuberculosis Association, in their recommendation that all hospital and clinic admissions should be x-rayed;

Resolved, that we recommend voluntary chest x-ray screening of all hospital and clinic patients, and urge endorsement of this recommendation by The Medical Society of New Jersey and its Component County Societies.

Dr. Schaaf moved that the above resolution be approved in principle and that the hospitals in New Jersey be so notified. Seconded and unanimously carried.

Public Relations

1. That the Executive Officer of the Society be designated ex-officio Executive Secretary of the Subcommittee on Public Relations and that public relations activities hereafter be considered an integral part of the functioning of the Executive Office.

The above recommendation was approved.

2. Dr. Henry A. Davidson, Executive Secretary of the Subcommittee on Public Relations, has asked to be relieved of his duties as of April 30, 1947.

Dr. Schaaf moved that Dr. Davidson's resignation be accepted with regret. Seconded by Dr. Costello and unanimously carried.

Medical Practice

1. From the Advisory Committee on Radiology—The Committee would like to call to the attention of the committee on legal procedures the action taken by the joint council of Radiologists, Pathologists, Anesthesiologists and Physical Therapy Physicians of New York in preparing a memorandum which was submitted to the Superintendent of Insurance of the State of New York, calling attention to the fact that although the hospitals and Hospital Service Plans are authorized by the Superintendent of Insurance to furnish hospital care only, they are actually contracting to provide x-ray and pathological examinations including diagnosing, and is therefore, clearly illegal. The Committee therefore recommends that the state committee study and obtain an opinion from legal counsel as to whether or not the hospitals and the New Jersey Hospital Plan are not, in fact doing a similar illegal act, that is, providing services in the form of diagnosis for which they are not legally incorpor-

ated. The Welfare Committee requests that the Trustees seek advice of counsel on the above.

Dr. Johnsen moved that the above recommendation be approved after deleting the following: "that is, providing services in the form of diagnosis for which they are not legally incorporated." Seconded and uanimously carried.

2. From the Advisory Committee on Laboratory Medicine—

(a) Resolved, that the State Medical Society disapprove of the VA plan for pension examinations insofar as it may conflict with the expressed viewpoint of the Board of Trustees as regards its exploitation of the clinical pathologist (and roentgenologist). Without in any way altering the plan this exploitation can be eliminated by allocation of the fees for laboratory and x-ray work to the doctor in charge of these departments. The hospital can and does collect a fee for its facilities and administrative overhead.

The above resolution was disapproved.

(b) Resolved, that the Board of Trustees be requested to establish a Section on Clinical Pathology, in order to strengthen the standing of clinical pathologists as practitioners of specialty in the practice of medicine, with the understanding that this will not entail the holding of scientific sections at the annual meeting.

The above resolution was approved.

Dr. Schaaf moved that the various other groups which have requested sections—Anesthesia, Orthopedic Surgery and Venereal Disease—be recognized as sub-sections of other sections or the general sessions. Seconded by Dr. Stahl and unanimously carried.

REPORT OF ACTING PRESIDENT

1. *Cancer Clinic*—Dr. Schaaf reported that he had met further with the group from the Mountainside Hospital and the Cancer Society relative to the establishment of a cancer clinic in that hospital, and that the differences between the Medical Society and the Cancer Society have been ironed out. The plan for operating the clinic has been made to conform with the established principles of private practice. They agreed to discriminate between the indigent and those who can afford to pay. They have also agreed to limit those who "come off the street" to residents of the area in which the hospital is established, and in the future will not approve any set-up where patients are not referred by a physician. Dr. Schaaf is to meet with the Board of Trustees of the Cancer Society on March 18, and it is expected that the Mountainside Hospital clinic will be in operation soon thereafter.

2. *Revision of Nusing Practice Act*—Dr. Schaaf called attention to the bill to revise the Nursing Practice Act (Senate 50) and stated that there was considerable controversy betweeen the Nurses' Association and the Hospital Association relative to its provisions.

Dr. Schaaf moved that if approached the Medical Society should state that action on Senate 50 has been tabled. Seconded by Dr. Lance and carried.

(Note: Subsequently the Hospital Association and the Nurses' Association agreed on amendments to S-50 and both groups are desirous of having the bill passed.)

3. *Executive Officer*—Dr. Schaaf reported that Dr. Lee D. VanAntwerp has declined the offer of the position as Executive Officer of The Medical Society of New Jersey, and requested that the Trustees instruct the committee as to future activities.

Dr. Fithian moved that the committee continue in its investigation for a suitable Executive Officer and that it be the sense of the Board that a layman would be acceptable if no physician can be found. Seconded and unanimously carried.

INSPECTION OF OSTEOPATHIC SCHOOLS

Dr. Johnsen reported that he had had a reply from Dr. Victor Johnson, Secretary of the Council on Medical Education and Hospitals of the A.M.A., stating that the Council is willing to undertake the survey of the two osteopathic schools, Philadelphia and Los Angeles, provided it is fully understood that the inspection will be to determine not whether these are acceptable osteopathic schools, but whether they are acceptable medical schools, and provided also that these schools request the Council to make the survey. These are the conditions under which the A.M.A. inspects any school.

As Chairman of the Committee on Osteopathic Relations, Dr. Johnsen offered the following resolution:

Resolved, that the Board of Trustees request the New Jersey State Board of Medical Examiners to request the Philadelphia College of Osteopathy and the Los Angeles College of Osteopathy to request an examination and inspection by the Council on Medical Education and Hospitals of the American Medical Association.

In the event that these schools refuse to comply with this request it is then requested that the New

Jersey State Board of Medical Examiners be urged to remove the names of these two schools from the approved list of accepted professional schools.

Dr. Johnsen moved that the above resolution be approved. Seconded by Dr. Coleman and unanimously carried.

REPORT OF INSURANCE COMMITTEE

Dr. Costello reported that he had contacted the home office of the United States Fidelity and Guarantee Company in Baltimore relative to obtaining further coverage for a member of the Essex County Medical Society, and emphasized the point that the Trustees believe that all of our members should have whatever coverage they request.

The following reply has been received:

Dear Dr. Costello:

In your letter of February 8 you state that you would like to have my reaction to two requests. One is that it was the feeling of one of the members that the Society should go further than the local office with the view of getting further coverage for Dr. Hubbard. My reaction to that request is that there is no use going further than the local office as we here in the Home Office have given this case careful consideration and are in full accord with the position that has been taken by our Manager, Mr. Rogers.

The second request is that it was the feeling of this member that any member of the State Society should have any coverage that he elects to take. If we should comply with that request it would mean, in effect, that we would be giving up our right of underwriting our business. We have absolutely no intention of giving up that right. We always have and always will reserve the right to determine what liability we assume under the policies that we issue.

You state that you would be pleased to discuss these two questions verbally with me and ask that I advise you when it will be convenient. I am always perfectly willing to discuss any phase of our business but frankly, Dr. Costello, I think it would be a waste of time on your part and mine to discuss these two questions or requests.

Furthermore, I would like to point out to you that Mr. Rogers is, as you know, our manager in Newark and he is perfectly capable and has authority to discuss any of these questions which may arise in his territory or are in connection with the business written through his office.

If you still feel that you would like to discuss these questions verbally with me and will so advise me, I will try to make arrangements to meet you at a time that will be convenient for you.

Very truly yours,
(Signed) JOSEPH F. MATTHAI,
Vice-President.

HONORARY MEMBERSHIP

Dr. Hawkes, Chairman of the Honorary Membership Committee, reported that he had received a recommendation from the Welfare Committee nominating Mr. William H. MacDonald of the State Department of Health for Honorary Membership in The Medical Society of New Jersey. Dr. Hawkes recalled that last year Mr. John S. Thompson, a member of the Board of Trustees of the Medical-Surgical Plan, had been suggested for Honorary Membership.

Dr. Hawkes recommended that in the event the amendment to the Constitution, permitting election of non-medical persons as Honorary Members of The Medical Society of New Jersey, is passed at the forthcoming meeting of the House of Delegates, Mr. Thompson's nomination be given preference.

Dr. Schaaf moved that the Board of Trustees approve the recommendation of the Honorary Membership Committee as it applies to Mr. Thompson, and that Mr. MacDonald be considered in 1948, with special preference. Seconded and unanimously carried.

WOMAN'S AUXILIARY

Dr. Dodd, Chairman of the Advisory Committee to the Woman's Auxiliary, presented for approval of the Board the following proposed projects of the Woman's Auxiliary, all of which have been approved by the Advisory Committee:

1. In order to coordinate the activities of the Woman's Auxiliary with those of The Medical Society of New Jersey for the coming year, it is proposed that the Woman's Auxiliary hold a "Work Shop Day" at the Society's Headquarters in Trenton in the spring or early summer at which time the chairman of each of the subcommittees of the Welfare Committee meet with the chairman of a similar committee of the Woman's Auxiliary to which would be invited the corresponding chairman of each component county auxiliary. The purpose of this meeting would be to acquaint the Woman's Auxiliary and each of its component county units with the work of the Medical Society in the scope of each of these committees; to promote discussion of mutual problems; and to aid in formulating a program of endeavor which will be of utmost benefit to the public and to The Medical Society of New Jersey.

2. It is proposed that the Woman's Auxiliary hold a round table conference at the State Society Headquarters in Trenton on problems of interest to women in the field of health, to which would be invited representatives from all state organizations of women. For purposes of discussion this conference could be divided into sections. One section would be presided over by a prominent educator; another by a prominent judge; another by a public health nurse; another by a leader in the field of home safety, and so on. It is proposed to

hold this meeting near the time of the annual meeting of the American Medical Association in order that prominent speakers attending the A.M.A. Convention might be secured to speak before this conference.

3. As an outgrowth of the conference just proposed, should it be successful, it is proposed that the Woman's Auxiliary hold an all day institute on health problems of interest to the women of New Jersey during Health Week this October.

The above projects were approved.

At the suggestion of Dr. Sica that Officers of the Auxiliary be invited to attend Welfare Committee meetings, Dr. Schaaf moved that the Officers of the State Auxiliary and the Presidents of the County Auxiliaries be notified of meetings of the Welfare Committee and invited to attend. Seconded by Dr. Sica and unanimously carried.

EDITORIAL OFFICES

Dr. Barkhorn informed the Board that Dr. Henry A. Davidson has accepted a position with the Veterans Administration, and presented the following recommendations from the Publication Committee:

1. That Dr. Henry A. Davidson be retained as part time Editor of The Journal at a salary of $1200 per year, to write editorials, edit scientific material, arrange for fill and prepare the dummy.

2. That Mrs. Miriam Armstrong be given the title of Assistant Editor, and that she be given increased remuneration.

3. That an additional clerk be hired to assist in the Journal office.

Dr. Costello moved that the recommendations of the Publication Committee be concurred in. Seconded by Dr. Schaaf and unanimously carried.

COMMUNICATIONS

Hospital Council, Inc. requested the name of a representative from The Medical Society of New Jersey to serve on the Board of Trustees of the Hospital Council. (Dr. Barkhorn, the incumbent, has asked to be relieved of this appointment.) The Council would also like to have the name of another member of this Society as a representative on the Council.

Dr. Costello moved that the selection of these two representatives be left in the hands of the Acting President with power to act. Seconded and unanimously carried.

Dr. Schaaf selected Dr. E. LeRoy Wood for Trustee, and Dr. Otto G. Matheke for the Council.

Dr. Casselman, Acting Chief of the Division of Venereal Disease Control, suggested that our recommendation to the Department of Health that a diagnosis of syphilis not be made unless two Mazzini tests, taken not less than two weeks apart, are both 4 plus be reworded as follows:

That a diagnosis of syphilis not be made solely on serologic evidence unless two Mazzini tests, or tests of similar sensitivity, taken not less than two weeks apart, are both 4 plus.

The revised wording of the recommendation was approved.

Dr. Green read communications from Dr. W. James Marquis and Dr. William H. Seward relative to the exclusion of x-ray services in hospital insurance plans.

Dr. Costello moved that the letters be placed on file, pending advice of counsel as requested by the Advisory Committee on Radiology. Seconded and unanimously carried.

A communication from the Essex County Medical Society relative to the section of the Medical Practice Act which has to do with corporate practice of medicine was referred to the Committee on Legislation.

Communications from the Board of Children's Guardians and the Division of Old Age Assistance relative to our recent request for increased physician's fees in treating cases cared for by these agencies were referred to the committee appointed to consider establishment of fees for treatment of cases under the Crippled Children Commission.

The Hospital Service Plan of New Jersey requested the nomination of a member of this Society for election to the Board of Trustees of the Hospital Service Plan.

Upon motion, seconded and unanimously carried, it was directed that the Hospital Service Plan be advised that the incumbent, Dr. Joseph F. Londrigan of Hoboken, is renominated.

PHYSICIANS CONTRACTS WITH HOSPITALS

Dr. Lance suggested that counsel be asked to study contracts made by various roentgenologists and pathologists with hospitals, with a view to clarifying the position of these physicans and determining the type of contracts they desire.

It was directed that this matter be included when seeking advice of counsel as requested by the Advisory Committee on Radiology.

The meeting was adjourned upon motion at 3:35 p. m.

NUTRITION IN EVERYDAY PRACTICE

S. William Kalb, M.D., Chairman, Nutrition Committee, Newark

1. *Some people don't like oranges, grapefruit, or tomatoes. Is there any other fruit high in ascorbic acid which they can have?*

   Strawberries contain twice as much ascorbic acid as tomatoes and much more than citrus fruits.

2. *I have a patient who has in the past few months developed an anorexia for fats. He will not eat butter, milk, cream, cheese, fat meat, or fried foods. Previously he was fond of these foods but since this episode began he has lost thirty-seven pounds. Is there a nutritional deficiency?*

   A lack of appetite for fats usually means a neoplasm of the pancreas. Check with x-ray.

3. *A detail man for a drug house advised me to use folic acid in the anemias which I have been doing but my results are not satisfactory. Why?*

   Folic acid is of little or no value in secondary anemia. Its best results are demonstrated in macrocytic anemia and pernicious anemia.

4. *Will vitamins help patients with post traumatic confusional states who do not yield to insulin or fever therapy?*

   Nicotinic acid 250 mg. orally and 50 mg. intravenously daily for one week will usually bring about the desired result.

5. *Why are high fat diets not tolerated in infectious hepatitis?*

   On the contrary, patients on diets high in fat and high in protein do better than those on low fat diets. The source of the fat must come from milk, cream, and butter. These fats are relatively high in unsaturated fatty acids and fatty acids of comparatively short carbon chains.

6. *Is it necessary for aged people to take vitamin B complex?*

   Not unless a deficiency of these vitamins is evident. More important as a prophylaxis against infirmities of old age is vitamin C. This vitamin should really be called "the tonic of the aged."

NEUROPSYCHIATRIC FACILITIES IN GENERAL HOSPITALS

On March 5, 1947, a meeting was held at the Home of The Medical Society of New Jersey at which representatives of the Mental Hygiene Advisory Committee met with representatives of the N. J. Hospital Association. Present were Doctors Samuel Blaugrund (Chairman, Public Health Committee), Henry A. Cotton, Jr. (Chairman, Mental Hygiene Committee), John Davis (Member, Mental Hygiene Committee), Emil Frankel, Director of Research, State Department of Institutions and Agencies), Dr. George Stevenson (Director, National Committee for Mental Hygiene), as well as Messrs. Frank Gail and George Buck of the New Jersey Hospital Association.

Purpose of the meeting was to discuss a recommendation by the Mental Hygiene Advisory Committee to the effect that general hospitals should be encouraged to develop mental hygiene and psychiatric services on the same basis as accorded other medical specialties. This should mean some decrease in the admissions to mental hospitals and a decrease in the number of advanced and helpless psychoneurotics. The Committee realized that there is a shortage of psychiatrists at present and that the program would have to be on a long term basis. However, it was felt that the hospitals would at least take action of setting up staff positions for neuropsychiatrists and openings would thus be available which would encourage more physicians to take up this specialty.

Dr. Blaugrund said that the Welfare Committee of the Medical Society had endorsed this recommendation.

Dr. Stevenson discussed the problem from a national standpoint and said that in a number of other states similar moves were being made but that so far the program was chiefly on paper. However, there were certain exceptions in that several general hospitals had already developed out-patient and even in-patient neuropsychiatric services. Dr. Stevenson pointed out that with soundproofing and air-conditioning it was possible to establish a disturbed psychiatric ward in a general hospital in such a way that these patients would not disturb the rest of the institution. Such a

project would not be advisable except for hospitals of at least 500 beds.

Mr. Gail and Mr. Buck discussed the question and expressed themselves as favorably inclined toward such a program. They promised to take the matter up with the trustees of the N. J. Hospital Association at the next meeting.

In a general discussion it was agreed that the development of out-patient neuropsychiatric facilities and the presence of a qualified neuropsychiatrist on the staff of the general hospitals throughout the State would have the following benefits:

1. Some of the load would be taken off the already overburdened traveling mental hygiene clinics operated by the State.

2. It would result in earlier diagnosis and treatment of neuropsychiatric cases.

3. The presence of a psychiatrist on the staff of general hospitals on an equal footing with other medical specialists would result in education of the medical profession generally with regard to psychiatric disorders.

4. It would bring neuropsychiatry closer to the general hospitals and thus closer to the public, removing some of the stigma which still is attached to the larger mental institutions.

THE MEDICAL SOCIETY OF NEW JERSEY
SUPPLEMENTARY LIST NO. 1 TO THE 1947 OFFICIAL LIST

Alexander, Walter G., 48 Webster pl., Orange (7)
Anderson, Windom E., 481 Broad st., Newark (7)
Angelillo, Marc C., 177 Elwood av., Newark (7)
Aronoff, Solomon, 4000 Bergenline av., Union C. (9)
Austin, Thomas R., 19 Holly st., Cranford (20)
Baker, Augustus L., 389 W. Blackwell st., Dover(14)
Balsbaugh, Edward F., 440 E. Broad st., Westf'd(20)
Baum, Otto S., 406 Centre st., South Orange (7)
Beall, William, Clarksboro (8)
Bekampis, Eugene H., 315 E. Maple av., Merc'tv'le(4)
Berman, H. Robert, 299 Clinton av., Newark (7)
Boland, Lucy E., 27 Washington av., Arlington (9)
Bomar, Wirrion L., 310 Plainfield av., Plainf'ld (20)
Bresev, Morris, 20 Tonnele av., Jersey City (9)
Brock, Howard F., 417 W. Broad st., Westfield (20)
Broselow, Benjamin G., Delsea dr., Franklinville (8)
Burkett, J. Paul, 215 Delaware st., Woodbury (8)
Caldwell, Julius A., 45 S. Mountain av., Montclair(7)
Carlin, Edward J., 1423 Irving st., Rahway (20)
Casselman, Arthur J., 301 N. Second st., Camden (4)
Cassini, Henry C., 27 Tremont av., East Orange (7)
Cerreto, Frank R., 395 Roseville av., Newark (7)
Chiger, Alexander S., 621 High st., Newark (7)
Choffy, Sylvester A., 202 Bergen av., Jersey City (9)
Clinton, Joseph A., 339 Park av., Newark (7)
Cohen, Herman N., 108 - 13th st., Hoboken (9)
Conover, Elizabeth N., 129 Summit av., Summit (20)
Conti, Michael, 280 Fourth st., Jersey City (9)
Coughlin, John P., 128 Wegman pkwy., Jer. City (9)
Dalberg, Walter, 500 Cherry st., Elizabeth (20)
Darby, C. Eugene, 620 Atlantic av., Ocean City (5)
David, Leopold S., 326 Cooper st., Camden (4)
Del Baglivo, Mario G., 10 Centre av., Secaucus (9)
deVries, John K., 144 S. Harrison st., E. Orange (7)
Dobson, Clarence D., 742 Greenwood av., Union (20)
Driscoll, Raymond S., 99 West 41st st., Bayonne (9)
Elliott, Frazier J., 10 N. 2nd st., Hammonton (1)
Featherston, Daniel F., 601 Bangs av., Asbury P.(13)
Felitti, Vincent J., 6 - 75th st., No. Bergen (9)
Firtel, Saul I., 1060 Broad st., Newark (7)
Fissell, George M., 530 Orange st., Newark (7)
Frankel, Theodore H., 600 Crescent av., Plainf'd(20)
Freeman, Joseph, 146 West 32nd st., Bayonne (9)
Friedlander, Ervin W.,213 Westfield av.,Elizab'h(20)
Friedman, Gustav, 351 Totowa av., Paterson (16)
Friedrich, Adam H., 47 Clark st., Manasquan (7)
Frutig, Harold C., 508 - 80th st., North Bergen (9)
Furman, Sol T., 344 Fairmount av., Jersey City (9)
Garrison, Sherman, Jr., Cooper Hospital, Camden (4)
Gelber, Isaac, 712 N. Broad st., Elizabeth (20)
Giannini, Francis F., Mine Brook rd., Far Hills (18)
Gilligan, Walter W., 164 Forest av., Glen Ridge (7)
Goff, Frank J., 62 Maple av., Red Bank (13)
Goldstone, Karl H., 349 Edgew'd av.,W. Englew'd(9)
Gorenberg, Harold, 55 Bentley av., Jersey City (9)
Green, Morris, 5011 Hudson av., W. New York (9)
Haines, Emerson S., 500 - 8th av., Asbury Park (13)
Harris, William G., Main st., Mullica Hill (8)
Haschec, Walter, 690 South 19th st., Newark (7)
Hasney, Frederick A., 292 Main st., W. Orange (7)
Hekimian, Jacob H., 2314 Palisade av.,Weeh'wk'n(9)
Higgins, Thomas F., 224 Monmouth rd.,Elizabeth(20)
Hill, Clarence T., 116 E. Hazelwood av., Rahway(20)
Hill, James O., 84 Barclay st., Newark (7)
Hollywood, James L., 219 Danforth av., Jer. City(9)
Holtzman, Michael, 734 N. Broad st., Elizabeth (20)
Hudson, Howard S., 824 Wesley av., Ocean City (1)
Ingling, Harry W., 51 W. Main st., Freehold (13)
Jacks, Oscar, 476 Mercer st., Jersey City (9)
Jarecki, Max, 905 Bergh st., Asbury Park (13)
Knight, Augustus S., Far Hills (18)
Kooperman, Barnett, 321 - 60th st., W. New York(9)
Kosminsky, Louis, 321 - 60th st., W. New York (9)
Larsson, Evert A., N. J. State Hospital, Trenton(11)
Laurusonis, John, 319 Broad st., Gibbstown (8)
Lease, Henry, 111 - 74th st., Woodcliff (9)
Lefkowitz, Jacob H., 445 - 64th st., W. New York(9)
Llull, Gabriel, 266 Morris av., Springfield (20)
Loizeaux, Edward C., 320 E. 7th st., Plainfield (20)
Loori, William A., 549 Pavonia av., Jersey City (9)
Lorenze, Edward, 196 Prospect st., East Orange (7)
MacDonald, W. Stanley, 1 N.Brookw'd dr.,Montcl'r(7)
Mahoney, Frank W., 22 Gifford av., Jersey City (9)
Mandell, Sidney N., 313 Monastery pl., Union City(9)
Mangelsdorff, Arthur F., Washington Valley rd., Martinsville (18)
Mangone, Edith, 174 Clinton av., Jersey City (9)
Margolin, Samuel J., 1012 - 80th st., N. Bergen (9)
Maturi, Vincenzo E., 814 Boulevard, Bayonne (9)
McAfoos, Louis G., Jr., 608 Eldridge av., W. Collingswood (4)
McCullough, Walter A., Essex Co. Hosp., Cedar G.(7)

McGeary, John A., 610 Salem av., Elizabeth (20)
McGuire, William A.,29 W.Wash'gt'n st.,Paulsboro(8)
McNeely, Julia A., 117 Washington st., E. Orange(7)
Milanesi, Armand M., 614 - 79th st., No. Bergen (9)
Monaco, Dante P., 436 Roseville av., Newark (7)
Morganstein, Louis K., 813 Avenue C, Bayonne (9)
Motzenbecker, William J., 16 Milford av., Newark (7)
Nelson, Harry, 36 Lupton av., Woodbury (8)
Norwich, Louis E., 355 Avenue C, Bayonne (9)
O'Connor, John J., 2124 New York av., Union City(9)
Pearlman, Saul J., 579 Broadway, Paterson (16)
Preminger, Max, 822 Park av., Plainfield (20)
Ravitz, Israel, 4 Newman av., Verona (7)
Reingold, Alexander, 221 Garden st., Hoboken (9)
Richardson, Emma M., 581 Stevens st., Camden (4)
Rigeron, George, 160 Willard av., Bloomfield (7)
Riggins, Edwin N., 161 N. Arl'gton av.,E.Orange(7)
Rosenthal, Abraham, 43 - 3rd av., Atl. Highl'ds(13)
Rossi, Bart, 564 Central av., Bound Brook (18)
Rudomanski, Victor, 103 Duke st., Kearny (7)
Russell, David L., 690 Bergen av., Jersey City (9)
Russell, Marie E., 583 Haddon av., Collingswood (4)
Santangelo, Stephen, 461 Jersey av., Jersey City(9)
Schneider, Harry M., 89 Gifford av., Jersey City (9)
Schorr, Herman E., 26 Lincoln Pky., Bayonne (9)
Schwab, George P., 7914 Boulevard, No. Bergen (9)
Schwarz, Henry J., 8534 Boulevard, No. Bergen (9)
Seligmann, Fred S., 501 - 32nd st., Union City (9)
Shaner, Ralph D., 94 Hillside av., Nutley (7)
Shapiro, Edward, 750 Avenue C, Bayonne (9)
Shapiro, Nathaniel J., 212 Palisade av., Union C.(9)
Sharbaugh, George B., 212 W. State st., Trenton (11)
Sivolella, Nicholas A., 245 Clifton av., Newark (7)
Smalley, Sara D., 530 Clifton av., Newark (7)
Smith, Wilbur A., 393 - 7th av., N. Y. C. 1, N. Y. (4)
Solomon, Louis, 7 Tonnele av., Jersey City (9)
Stark, Harry L., 680 Boulevard, Bayonne (9)
Suesserman, Henry, 389 Lyons av., Newark (7)
Swiney, Juliana, 325 Avenue C, Bayonne (9)
Teskey, Stanley, 10 Anderson rd., Bernardsville(14)
Tomaiuoli, Michele, 19 - 76th st., No. Bergen (9)
Toren, Julius A., State Hospital, Marlboro (13)
Vitolo, Ralph E., 934 Orchard ter., Linden (20)
Waldron, Edward L., 910 Stuyves't av., Trenton(11)
Walsh, John D., 310 Park av., Hoboken (9)
Washington, William H., 321 High st., Newark (7)
Weiner, Harry S., 283 Franklin st., Bloomfield (7)
Woltz, Sidney, 2206 New York av., Union City (9)
Ziegler, Fred, V. A. Center, Los Angeles, Cal. (4)

ASSOCIATE MEMBERS

Bielski, Johannes F., 190 Somerset st.,N.Br'nsw'k(12)
Fernicola, Anthony R., 565 Mt. Prosp't av.,N'w'k(7)
Hill, Arthur G., 183 Grove st., Montclair (7)
Koralek, Adolph H., 31 Lincoln Park, Newark (7)
Lotman, Harry, 987 Sanford av., Irvington (7)
Sadoff, Irvin E., 163 New St., New Brunswick (12)
Scolamiero, Pasquale J., 248 Shepard av., E. Or. (7)
Shaffrey, Thomas A., 107 Laurel av., Irvington (7)
Stevens, Donald J., 42 Chancellor av., Newark (7)

QUESTIONS ON NARCOTIC REGULATIONS

Information from Bureau of Narcotics, Washington, D. C.

1. *What records should be retained by the individual physician and for how long?*

All physicians should keep a daily record showing the kind and quantity of narcotics dispensed or administered, the name and address of each person to whom dispensed or administered and the purpose for which dispensed or administered. This record should be retained for a period of two years. Physicians are not required to keep a record of narcotics to persons upon whom, in the course of professional practice, they are in personal attendance.

2. *What is the status of prescribing for marihuana?*

Marihuana may be prescribed or dispensed in good faith and for medical purposes by a physician registered in Class 4, under the Federal marihuana law.

3. *What should the physician do if he is treating a drug addict by gradual withdrawal or if he proposes to prescribe opiates for a patient suffering from a hopeless or fatal disease who is in great pain?*

The Bureau of Narcotics has never sanctioned or approved the socalled reductive ambulatory treatment of addiction for the reason that where the addict controls the dosage he will not be benefited or cured. Medical authorities agree that the treatment of addiction, with a view to effecting a cure, which makes no provision for confinement while the drug is being withdrawn, is a failure, except in a relatively small number of cases where the addict is possessed of a much greater degree of will power than that of the ordinary addict. In this connection, the following is quoted from the Journal of the American Medical Association, published on June 14, 1924:

> Your committee desires to place on record its firm conviction that any method of treatment for narcotic drug addiction, whether private, institutional, official or governmental, which permits the addicted person to dose himself with the habit-forming narcotic drugs placed in his hands for self-administration, is an unsatisfactory treatment of addiction, begets deception, extends the abuse of habit-forming narcotic drugs, and causes an increase in crime. Therefore, your committee recommends that the American Medical Association urge both Federal and State governments to exert their

full powers and authority to put an end to all manner of such so-called ambulatory methods of treatment of narcotic drug addiction, whether practiced by the private physician or by the socalled "narcotic clinic" or dispensary.

In the opinion of your committee, the only proper and scientific method of treating narcotic drug addiction is under such conditions of control of both the addict and the drug, that any administration of a habit-forming narcotic drug must be by, or under the direct personal authority of the physician, with no chance of any distribution of the drug of addiction to others, or opportunity for the same person to procure any of the drug from any source other than from the physician directly responsible for the addict's treatment.

A physician may prescribe or dispense narcotics in good faith and for medical purposes to a person suffering from an incurable disease requiring the administration of narcotics. Care should be exercised that there is not made available to the patient a quantity of narcotics greater than that necessary to meet his bona fide medical needs, in order that there may be no opportunity for diversion of a portion of the supply for improper purposes. In this connection, the following is quoted from a series of articles published in the Journal of the American Medical Association from March 14 to June 6, 1931:

Physicians may, by the exercise of more thought in practicing, do much to avoid censure in relation to narcotic addiction. They may substitute, whenever possible, non-habit-forming drugs in the place of morphine or other opium alkaloids. When narcotics are indispensable, however, as shown in this series of articles, no more should be administered than is necessary to achieve the desired end. Patients requiring daily administration should be seen often by the doctor and the amount of drugs ordered or supplied should not exceed that required by the patient until seen again. Independence of administration on the part of nurses should be strictly limited to prescription and any change in treatment should be in writing.

4. *If a physician returns to private practice from military or naval service, what steps does he take to re-establish his narcotic license?*

A physician who returns to private practice from military or naval service should obtain an application for registration from the collector of internal revenue of the district in which he proposes to practice. The application should be executed and returned to the collector with the tax of $1.00.

5. *What is the procedure for closing out the registration and drug supply when a physician dies?*

In the case where a physician dies, his tax stamp and unused order forms should be returned to the collector of internal revenue for cancellation. Narcotic drugs in unbroken packages may be returned to the wholesale dealer from whom purchased pursuant to an order form of the wholesaler. Narcotic drugs in broken packages may be disposed of to a registered physician or druggist pursuant to an order form or such drugs may be surrendered to the narcotic district supervisor for destruction.

6. *How and to whom should a doctor report a theft of his bag containing drugs or the burglary of his office supply of narcotics?*

Where narcotics are lost by theft, the physician should immediately notify local police. He also should file with the Narcotic District Supervisor a sworn statement of the facts surrounding the loss, including a list of the narcotics stolen, and documentary evidence that the local authorities were notified. A copy of the sworn statement should be retained and filed with the other narcotic records of the physician.

OBITUARY

DR. THOMAS McG. BRENNOCK

Dr. Thomas McG. Brennock, 52, of Jersey City, former president of the Hudson County Medical Society and a diagnostician for the Jersey City Board of Health, died on April 3 after a brief illness.

A native of Albany, N. Y., Dr. Brennock was graduated from the University of Pennsylvania Medical School in 1917. He served his internship and residency in surgery at Christ Hospital, Jersey City. Dr. Brennock established his practice in Jersey City following his service in World War I.

He was a member of the executive committee of the Hudson County Medical Society, the Military Surgeons of America, and a fellow of the New York Academy of Medicine, the American Medical Association and the American College of Surgeons. He was also attending gynecologist at the Medical Center and attending surgeon at the Margaret Hague Maternity Hospital, Greenville Hospital and Fairmount Hospital.

Dr. Brennock was active in county and state society affairs. At the time of his death he was chairman of the Scientific Program Committee and a member of the Annual Meeting Committee.

MEDICAL-SURGICAL PLAN *

1. *What is it?*

Medical-Surgical Plan is a non-profit medical service corporation, organized by The Medical Society of New Jersey under the provisions of Chapter 1, Title 15 of the Revised Statutes of New Jersey entitled "Corporations and Associations not for Profit", and operating under the provisions of Chapter 48-A, Title 17 of the Revised Statutes entitled "Medical Service Corporations".

2. *What does The Medical Society have to do with Medical-Surgical Plan?*

The Plan was organized by The Medical Society of New Jersey. It has the formal approval of each of the 21 component County Societies. The members of the Board of Trustees of the Plan are elected from nominees of The Medical Society of New Jersey.

3. *What is the relationship between Medical-Surgical Plan and Blue Cross?*

The Blue Cross Plan in New Jersey is the Hospital Service Plan of New Jersey. There is no corporate relationship between Medical-Surgical Plan of New Jersey and Hospital Service Plan of New Jersey. Each is a separate corporation. Applicants for enrollment in Medical-Surgical Plan must enroll (or already be enrolled) in Hospital Service Plan.

By contract between the two organizations the Hospital Plan enrolls the Subscribers, does the billing, collecting and general accounting of Medical-Surgical Plan. Medical-Surgical Plan maintains its own office for the purpose of handling all claims, matters pertaining to patient-physician relationship and disbursement of funds.

4. *How does a person enroll?*

Enrollments are conducted on the basis of group enrollment through place of employment, where arrangement can be made for the payment of the subscription rate of each subscriber by pay-roll deduction methods, and transmission of the subscriptions covering the group to the Plan by one check from the employer.

Currently the Plan requires the following percentages of enrollment:

Total Employees	*Required Applications*
10—50	75% but not less than 10 (whichever is greater)
51—100	50% but not less than 35 (whichever is greater)
101—up	30% but not less than 50 (whichever is greater)

5. *What does it cost the Subscriber?*

On the basis of group enrollment:

Single Contract $0.75 per month
Family Contract $2.00 per month

The "single" contract is available only to single persons. All married persons, (living together) must accept the "family" contract and include all eligible dependents.

Upon leaving a group the subscriber may continue a "single" contract by direct payment to the Plan of $12.00 annually or $6.10 semi-annually or $3.10 quarterly or the "family" contract by direct payment of $28.00 annually, or $14.10 semi-annually, or $7.10 quarterly.

6. *How many persons are enrolled in Medical-Surgical Plan?*

As of December 31, 1946, 88,088 persons were enrolled under effective contracts.

7. *What benefits are provided by the Plan?*

Basically the benefits payable by the Plan apply to services rendered by fully licensed physicians to persons admitted to hospitals for treatment. Eligible services include medical, surgical, obstetrical, anesthesia and consultation.

Exceptions to the requirement of hospital admission are:

1. Tonsillectomies performed in the offices of physicians.
2. Emergency surgical services rendered in the out-patient departments of approved hospitals without formal admission of patient for bed occupancy.
3. Emergency surgical services occasioned by accidental injury and rendered anywhere within 24 hours of the time of the accident, in accordance with the Plan's schedule of benefits but not to exceed $25.00 for any one accident.

8. *What about free choice of physician?*

The Plan allows free choice of physician from among fully licensed physicians of any state and does not interfere with professional matters pertaining to patient-physician relationship. The majority of subscribers and their enrolled dependents who are cared for by non-participating physicians are those cared for by physicians practicing in other states, particularly New York and Pennsylvania.

9. *How does a doctor become a Participating Physician?*

The Plan has about 3400 Participating Phy-

* This material was originally intended for the *New Jersey Doctor's Almanac*. Readers who do not keep copies of their JOURNAL are requested to clip this page and attach it to the inside back cover of the *Official List* and *Almanac*.

sicians who have signed the Plan's "Agreement with Participating Physician". These forms are obtainable through the office of the Plan or the office of The Medical Society of New Jersey.

10. *How is the doctor paid?*

The doctor is paid directly by the Plan.

The hospital to which the patient is admitted submits a "notice of hospital admission" to Hospital Service Plan of New Jersey.

If, according to records maintained in the office of the Hospital Plan, the patient is enrolled in Medical-Surgical Plan a transcript of the admission notice is forwarded to Medical-Surgical Plan office.

This "notice of admission" states the name of the physician admitting the case to hospital. Medical-Surgical Plan forwards to this physician a copy of its "Physician's Statement" upon which the attending physician submits his bill to Medical-Surgical Plan.

The Plan distributes checks to physicians on the 14th and 28th day of each month, covering all cases which have been reported and approved as of the 5th and 20th day of each month.

11. *What does the doctor do when the patient identifies himself as a subscriber? What forms does he fill out or what notification does he render?*

The physician renders no report at this time. The case will be handled by Medical-Surgical Plan automatically according to the administrative routine described under question No. 10.

12. *When is the Plan Payment deemed "not in full"?*

a. If the patient is admitted for, or transfers to, a private accommodation of one bed per room (unless transferred at the instance of the physician or hospital).

b. If the patient, admitted for a semi-private or ward accommodation, shall have agreed to pay the participating physician an amount additional to that payable by the Plan, or fails to disclose that he is enrolled under the Plan contract. However, no such additional amount shall be payable if, for the twelve calendar months immediately preceding the month in which the hospital admission occurs, the income of the subscriber under a Single Contract is less than $2,000; or the income of the subscriber under a Family Contract is less than $2,000, plus $500 for the first enrolled dependent (wife [husband] or child) plus $250 for each additional enrolled dependent.

c. If the patient is attended by a duly licensed physician who is not a participating physician, the Plan payment, based on the schedule of benefits, is toward, but not in excess of the physician's charge to the patient, and the Plan is not liable for any balance.

d. If the patient does not qualify for coverage of the physician's services in full as above explained, then the balance, if any, payable by the patient (or subscriber) is as shall have been agreed upon between patient and physician, and the Plan is not liable for any such balance.

13. *Where do I get further information?*

From the office of the Plan or the office of The Medical Society of New Jersey.

OFFICIAL ATTENDANCE

181st ANNUAL MEETING, APRIL 22-24, 1947
Haddon Hall, Atlantic City

	Delegates	Members	Total
Atlantic County	8	56	64
Bergen County	15	16	31
Burlington County	7	24	31
Camden County	12	47	59
Cape May County	4	5	9
Cumberland County	4	6	10
Essex County	61	113	174
Gloucester County	5	8	13
Hudson County	23	49	72
Hunterdon County	2	2	4
Mercer County	18	24	42
Middlesex County	8	36	44
Monmouth County	6	36	42
Morris County	10	14	24
Ocean County	2	7	9
Passaic County	14	21	35
Salem County	3	2	5
Somerset County	2	10	12
Sussex County	1		1
Union County	24	32	56
Warren County	3	5	8
	232	513	745
Visiting Physicians			27
Total Physician Registration			772
Auxiliary			253
Visitors			221
Exhibitors			128
TOTAL REGISTRATION			1,374

VETERANS CARE PLAN

Edward T. Yorke, M.D.
Liaison Officer with Veterans Administration

NEW METHOD OF BILLING VA

VA has put into practice a simplified method of authorization and billing, both of which will appear on a single form. Details regarding the new form were not available at the time of this writing, but VA has indicated its intention to release a bulletin to all physicians, explaining all features of the procedure.

SHOCK THERAPY

VA has discontinued the authorization of electric shock and other forms of shock therapy in the private offices of physicians. Such treatment will be given at the Veterans Hospital in Lyons. If shock therapy is indicated, submit a report of your examination to the Mental Hygiene Clinic, 37 Fulton Street, Newark 2, New Jersey, and instruct the veteran to visit that clinic.

COST OF DISPENSING

Physicians who dispense drugs to veterans under their care should *not* submit a bill to VA for the cost of the drugs. Arrangements have been made with pharmacies to fill prescriptions for veterans authorized to receive medical care by a private physician. The doctor simply writes his prescription in duplicate and states on it that he is authorized to treat the veteran. The Veterans Administration also operates a prescription service at Newark Regional office.

SPECIALISTS

Although eligibility of physicians to treat veterans is certified by the Liaison Officer, VA reserves the right to qualify specialists according to criteria separate from those established by the American Boards. The Liaison Officer may find it necessary to request that certain physicians give him information to permit their qualification as specialists by VA. A substantial index has already been prepared by the Liaison Officer. An effort will be made not to trouble those who have already submitted information regarding qualifications. Physicians desirous of listing as specialists, and not now so listed, may submit their qualifications to the Liaison Officer, with such a request. Address: Dr. Edward T. Yorke, Room 316, Veterans Administration, 20 Washington Place, Newark 2, N. J.

HOSPITALIZATION

Veterans who have service-connected defects may receive treatment for those defects by private physicians in *local hospitals*. VA authorizes local hospitalization because of the lack of beds allocated to VA in army installations. The institution at Lyons is not a general hospital. Only emergencies occurring in the nearby vicinity are treated there.

Whenever a veteran is admitted to a hospital without prior authorization from VA, request for authorization must be made within seventy-two hours.

Physicians who treat veterans should request authorization from VA within five days of the initial visit.

EXAMINING VETERANS

During the last two months, VA's need for the pension examination units in the counties has dwindled to a very small figure. During March, only Passaic, Bergen and Middlesex received letters for authorizations of a routine nature.

VA still feels that need for the examining units may become real, in view of the fact that indications point to a heavier load within the next six months. One large veteran's organization has demanded physical examinations of certain types of claim cases, which, if done, will cause considerable activity in pension examinations.

CAMP PHYSICIAN WANTED

The Big Brother Movement is seeking a physician to serve from July 2 to September 2, 1947, at their camp for underprivileged children at Stillwater, N. J. Salary is $150 to $200 for the season, plus full maintenance. Physicians interested in this position should communicate with Mr. R. J. Fornwalt, Big Brother Movement, 207 4th Ave., N. Y. C. 3.

VETERANS CARE PLAN

The following information is furnished by the Newark Regional Office and called especially to the attention of the physicians participating in the "own doctor" plan of treatment. The first section concerns neuropsychiatric patients; the second refers to all other treatment cases.

NEUROPSYCHIATRIC CASES

Veterans receiving treatment by private physicians for neuropsychiatric disabilities will be requested to report to the Veterans Administration every three months. Purpose of this visit will be to clarify obscure problems of eligibility for treatment, review the progress made under treatment and to evaluate the type of treatment given.

As of this date, all veterans seeking treatment for the first time for neuropsychiatric complaints will be requested to report to the Veterans Administration for purposes of clarifying their eligibility and for evaluating the complaints for indicated treatment.

It is important to note that eligibility for out-patient treatment of those veterans discharged more than one year from service raises special problems which require the most careful review by the Veterans Administration.

OTHER OUT-PATIENT CASES

In the interest of clarification, it is the desire of the Veterans Administration (Newark Regional Office) to call the attention of physicians of New Jersey to certain regulations and procedures of the Veterans Administration pertaining to veterans who have applied for or are under the care of physicians in their home communities.

Officials of the Veterans Administration designated to grant authorization for treatment from private sources at Government expense have the dual responsibility of safe-guarding:

1. The welfare of the veteran seeking treatment.
2. The welfare of the government of which the VA is an agency.

Guided by established regulations and procedures, these officials are responsible for:

1. *Proper determination of eligibility for treatment.* If either legal or medical eligibility is obscure, it may be necessary to have the veteran report to the nearest VA installation in order that such eligibility may be clarified both in the interest of the veteran and the Government.

2. *Securing the best possible treatment for the eligible veteran.* In the interest of the veteran, the Government and the medical profession in general, duly authorized officials of the VA must take proper steps to avoid:

a. Treatment not in accord with standards acceptable to the medical profession.

b. Over-treatment or unnecessary treatment; in this connection it may be necessary in certain cases for the authorizing official to reduce the number of treatments requested by the physician when it is clearly evident that the request is excessive.

c. Obviously unnecessary and indiscriminate requests for x-ray and clinical laboratory work when not warranted by clinical findings. Authority for such services cannot be properly granted.

3. *Proper follow-up of all cases authorized for treatment.* In the proper exercise of this responsibility, officials of the VA will find it necessary to request concise clinical reports and follow-up reports from treating physicians in cases which are under treatment for prolonged periods.

4. *Full utilization of VA facilities.* It is the responsibility of the Chief Medical Officer or his designate to assure that existing VA facilities are utilized to their fullest feasible extent in performing examinations and rendering treatment to eligible veterans.

These facts are called to the attention of all participating physicians so that there may be clear understanding about the out-patient treatment program of the Newark Regional Office. Continued cooperation between that Office and the medical profession will assure that this program will work out to the best interests of the veterans of New Jersey.

JEFFERSON ALUMNI ASSOCIATION

Atlantic Chapter of Jefferson Alumni Association in conjunction with the Jefferson Alumni Association will sponsor a Buffet Supper and Smoker in the American Room of the Traymore Hotel on Wednesday evening, June 11, 1947, at 7:00 p. m. For reservations and information contact Dr. David B. Allman, 104 St. Charles Place, Atlantic City.

NEW JERSEY STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH NEWS FOR THE PHYSICIAN

Laboratory Supplies Short

The Bureau of Bacteriology of the New Jersey State Department of Health is experiencing the same postwar laboratory supply problem that other laboratories throughout the country are facing. Deliveries of glassware, rubber stoppers, mailing containers, cardboard boxes, blood letting needles, and other supplies are long delayed and the increased cost of these articles is a burden on an agency with a fixed budget.

All reserve supplies of materials in the Bureau of Bacteriology have now been exhausted and the laboratory is operating on a day-to-day supply of mailing outfits. Yet the laboratory is being called upon to perform more examinations than ever before and must also supply the physicians now returning to practice with services and mailing outfits.

Medical practitioners can help the laboratory to a certain degree by returning any unused mailing outfits which are not needed, any incompletely assembled outfits or ones that have been stored because they are no longer believed sterile. They may be returned to Bureau of Bacteriology, New Jersey State Department of Health, State House, Trenton, New Jersey, postage or express collect.

YOUR HELP NEEDED IN THREE WAYS

Because of these supply shortages it is not possible to fill completely all supply orders received from physicians. In such cases partial orders are sent as far as supplies allow. Physicians should not order mailing outfits with needles if they do not intend to use the needles, and to order only the minimum supply needed for the immediate future.

With the help of the practitioners of the state, the Bureau of Bacteriology will be able to continue its services through the postwar period of shortages. We need the assistance of physicians in these three ways: (1) returning unused supplies, (2) ordering needles only as needed, and (3) restricting supply orders to immediate needs.

Public Health News Available

Public Health News, official bi-monthly publication of the New Jersey State Department of Health, is mailed gratis to those New Jersey physicians interested in public health. This publication presents timely and authoritative articles on many fields of public health administration. Your name will be placed on the mailing list if you send your request to the New Jersey State Department of Health, Health Education Division, Trenton 7, New Jersey. Also published by the Department is a monthly news sheet *The TB Controller* which presents news of the activities of the Tuberculosis Control Division in conducting industrial and community chest x-ray surveys. A request to the Department will put your name on the mailing list.

New Jersey Nurse Census

In spite of the good number of public health nurses employed in New Jersey, there are still areas in our state in which public health nursing services are greatly limited.

In these postwar years we face plans for an expanding health program in every city and village. This expansion comes at a time when we are facing a serious shortage of nursing personnel. Young people in greater numbers must be guided into schools of nursing. Only in this way can we be assured of a sufficient number of potential candidates to fill the public health nursing vacancies already mounting in agencies throughout New Jersey.

A special plea is being made to registered nurses in New Jersey to acquaint themselves with public health nursing as a possible future career. Activities in this field are stimulating and varied. They offer an opportunity for personal reward in the satisfaction of contributing to national health and security.

PHYSICIANS CAN HELP

Members of the medical profession are in a unique position to offer advice and counsel to the young members of the families they visit. Because the family doctor is looked upon with affection and trust, his suggestions about future career will be considered with interest and weight.

No one is better fitted to guide the interest of these young folks into the channels of nursing.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

The *Atlantic County Medical Society* held its regular monthly meeting on Friday, March 14, at the Traymore Hotel. DR. LAWRENCE WILSON, president, introduced the guest speaker, DR. EDWARD L. BARTZ, vice-president of the American Medical Association and chairman of the Council on Scientfic Assembly. Dr. Bartz spoke on *Certain Aspects of the Disorders of Later Years.*

He stressed that life expectancy has increased since the turn of the century. In 1944, life expectancy had exceeded 65 years and may reach greater proportions as the years go by. This progress has been due to the remarkable advance in the various fields of medicine.

Dr. Bartz listed the following as the most common disorders in the aged; cardiovascular, arterioslerosis, hypertension, nephritis, arthritis, cancer, anemia, and mental deterioration. Each was discussed briefly and the newer treatments mentioned, He placed antibiotics and anticoagulants at the top of the list. Fatigue and boredom are the major enemies of old age.

A few basic rules for vitality in later years were stressed as well as the difference between chronological and physiological aging. A lively discussion followed led by Drs. Read and Andrews. The president thanked the speaker on behalf of the society.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society,* held at Bergen Pines Hospital, Oradell, N. J., on the evening of February 11, 1947, was called to order by the President, DR. ALBERT W. CLOUD. at 9:15 p. m.

The minutes of the regular meeting of January 14 were accepted as read. Minutes of the executive committee meeting of January 21st, were approved as published in the *Bulletin.*

The following names for the 1947-1949 class to the House of Delegates of the Medical Society of New Jersey were presented by the chairman of the nominating committee, DR. FREDERICK C. DILGER: Delegates: Drs. H. B. Wilson, R. C. Schretzmann, L. A. Markley, E. V. Sexton, A. W. Cloud, John Olpp, Luke Mulligan, L W. Black; and Alternates: Drs. P. S. Busicco, R. R. Carrol, F. J. Fadden, Walter J. Farr, W. L. Jordan, C. Pallen, Joseph R. Helff, Donald Kissinger. Dr. Dilger then presented the following names for Delegate and Alternate to the State Nominating Committee: Delegate Dr. Frederick C. Dilger, and Alternate Dr. Albert W. Cloud. Dr. Dilger also announced that the above names will be published in the next *Bulletin* and will be submitted for vote at the next regular meeting.

On recommendation of the membership committee, the following applicants were elected to full membership: Drs. Eric C. Bayer, Dumont; William P. Magee, Palisade; J. Lloyd Morrow, Rutherford, and Samuel A. Weiss, Teaneck. Drs. Mortimer H. Kassel, East Paterson; Bernard Ross, Maywood, and Michael J. Russin, Garfield, were elected to Associate Membership.

The speaker of the evening, DR. RICHARD B. CATTELL, of Lahey Clinic, Boston, was introduced by Dr. Twinem. Dr. Cattell's topic was *"Newer Developments in the Treatment of Thyroid Disease".* He drew on the vast experience of the Lahey Clinic and delivered one of the most interesting papers of the year. Of greatest interest was the outline of the preoperative preparation with the newer antithyroid drugs, thiouracil and propyl thiouracil. He recounted the technical difficulties that had occurred following thiouracil alone. The main complication was excessive bleeding, which made the operation very difficult. This has been controlled to a great extent by giving potassium iodide before operation. At the present time, he is using propyl thiouracil with potassium iodide, given concurrently. While this somewhat prolongs the period of preoperative preparation, the result is on the whole, much more satisfactory than when the drugs were given separately. He also gave statistical evidence of the markedly lowered postoperative mortality rate following introduction of this type of therapy. A lively discussion followed the presentation.

The meeting adjourned at 11 p. m.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The regular monthly meeting of the *Burlington County Medical Society* was held on February 13, at the Riverton Country Club. President-elect DR. G. E. MCDONNEL, presided in the absence of the President, Dr. William Bray.

Dr. McDonnel called upon DR. MARCUS W. NEWCOMB, chairman of the committee on Constitution and By-Laws, to read the revised Constitution and By-Laws of the County Society. Following discussion, the revised Constitution and By-Laws met the approval of those present and was tabled until the March meeting when it will be voted upon.

DR. ARTHUR PEACOCK described the new improved Public Health Plan for the counties of New Jersey. This proposed new plan is a definite improvement over the one which is in force now and has some "teeth" in it which give the health officer authority to carry out the law.

The speaker of the evening was DR. MARCUS W. NEWCOMB who gave a "Report and Analysis of a Survey of Tuberculosis in Burlington County". Dr. Newcomb began the report by telling why and how the survey was started, and then turned over the main portion of the report to his assistants, Dr. Busanski and Dr. Krasnitz at Fairview Sanatorium. It was a very enlightening survey and proved the good work that Dr. Newcomb and his assistants are doing in a quiet but very thorough manner. The seventy millimeter film was found to be very efficient for screening purposes but could not be used for diagnostic work. It was found that of all

the persons x-rayed 1.2 per cent were active cases of tuberculosis. At the end of the report, x-ray pictures were shown of tuberculous patients and their cases discussed briefly. The talk was enjoyed by all those present.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

DR. HENRY B. DECKER, president, presided over the regular meeting of the *Camden County Medical Society* on February 4, 1947, at the Camden City Dispensary.

Guest speaker was HART E. VAN RIPER, M.D., Medical Director of the National Foundation for Infantile Paralysis. Dr. Van Riper gave an interesting talk on *infantile paralysis*. He stated that the diagnosis is as uncertain today as it was a hundred years ago.

Great strides have been made in the past year in treatment and there is now some danger of overtreatment. In treatment, we must first give attention to the saving of life. Then, we must consider the relief of pain and the restoration of the patient to the normal functional life by reeducation of the muscles involved. These patients should all be hospitalized. The Kenny regime is not considered a complete treatment.

There is considerable confusion as to the terms "bulbar" and "respiratory" types. The words are used interchangeably. At the University of Minnesota during the past epidemic, the bulbar type was divided as follows: (1) true bulbar, the involvement of the eighth and ninth nuclei; (2) respiratory center group; (3) involvement of the cardiac center; and (4) encephalitic type. It is very important to maintain an airway even if an intubation or tracheotomy is necessary. This has reduced the mortality rate fifty per cent. Oxygen saturation has given a good prognosis. Outcome is good in the true bulbar type. In the cardiac or circulatory group, the prognosis is the poorest.

Sedatives are contraindicated.

In the respiratory cases, it is important to remove the patient from the respirator as soon as possible.

Curare is not a cure; it is a dangerous drug. Dr. Van Riper did not recommend treatment by curare, overstretching the muscles or muscle substitution. Establishment of normal muscle function and the increase of muscle strength should be accomplished slowly. Patients should be taught to adjust themselves to any permanent disability.

A medical rehabilitation center should be available in all large cities. Such centers should have the benefit of a psychologist as well as vocational guidance.

The paper was discussed by Doctors Joseph C. Lovett, Keith Haines, Vernon Davis, Thomas K. Lewis, Fred Becker, H. Wesley Jack, William Scheffler and Oram R. Kline.

Dr. Albert E. Kay of Merchantville was elected a member of the Society.

DR. H. WESLEY JACK reported on the proceedings of the January meeting of the Welfare Committee of The Medical Society of New Jersey.

CAPE MAY COUNTY

C. W. Way, M.D., Reporter

The anual meeting of the *Cape May County Medical Society* was held on April 8, at 9:00 p. m., at the Old Court House Building, Cape May Court House, with President J. S. D. EISENHOWER, JR., presiding.

The following were elected to membership: Edward Tyson, Ocean City; R. Halpern, Wildwood, and Francis A. Hauck, Sea Isle City.

The following officers were elected for the coming year: President, J. S. D. Eisenhower, Jr.; Vice-President, H. H. Hornstine; Secretary, C. W. Way; Treasurer, Harold Hughes; Reporter, C. W. Way; Board of Censors, Marcia Smith.

The Society approved the plans for the new Burdette Tomlin Memorial Hospital, which call for a 68-bed modern general non-profit hospital to be located at the entrance of the Stone Harbor boulevard in Cape May Court House. Subscriptions thus far total more than $325,000. Officers of the hospital have announced that work will start on the institution in 1948.

A most interesting and instructive film on Gastric Ulcer was shown. Every member was urged to attend the anual meeting of The Medical Society of New Jersey at Haddon Hall in April, and also the 100th anniversary of the American Medical Association in Atlantic City in June.

ESSEX COUNTY

Felix J. Di Fino, M.D., Reporter

The President, DR. THOMAS W. HARVEY, called the regular monthly meeting of the *Essex County Medical Society* to order at 9:00 p. m., at the Academy of Medicine, 91 Lincoln Park, Newark, N. J., on Thursday, March 13. At this meeting, the topic, *Carcinoma of the Breast*, was most ably presented by DR. STUART W. HARRINGTON, Chief Surgeon, Surgical Section of the Mayo Clinic, Rochester, Minn.

In his talk, Dr. Harrington stressed the importance of an early diagnosis of the cancer patient, so as to insure favorable prognosis. Dr. Harrington demonstrated the success of radical surgery in advanced cases of carcinoma of the breast with a series of slides based on actual case histories. The highlight of the evening was a colored motion film of a complete radical mastectomy.

The following applicants were elected to membership:

For Transfer—Active: Otto S. Baum, South Orange; Edgar M. Braun, Newark, and John K. deVries, East Orange.

For Active: Morse A. Shepard, Newark (in service).

For Associate: A. R. Fernicola, Newark; Benjamin Geringer, Newark; Arthur G. Hill, Montclair; Adolph H. Koralek, Newark; Harry A. Lotman, Irvington; Pasquale J. Scolamiero, East Orange; Thomas A. Shaffrey, Irvington; Donald J. Stevens, Newark; Louis E. Zimmer, Newark.

An interesting talk on *Medicine in the America of Today and Tomorrow*, was the feature of the regular monthly meeting of the *Essex County Medical Society* held on Thursday, April 10, 1947, at 9:00 p. m., at the Academy of Medicine, Newark. DR. T. W. HARVEY, President, presided. The speaker

for the evening was Dr. William B. Rawls, who is Chairman of the Coordinating Council of the Five Medical Societies of greater New York. Dr. Rawls gave a very enlightening discussion on the problems facing organized medicine.

The following applicants were elected to membership:

For Reinstatement: Ulysses M. Frank, Newark.

For Transfer—Active: Joseph L. Brizard, Orange; J. Lawrence Gillespie, Arlington; Otto B. Hitschmann, Newark; Samuel B. Kesselman, Newark.

For Associate: Morris Bass, Newark; Wilfred P. Cockburn, Newark; Harvey P. Einhorn, Newark; Harry Merliss, Newark; Leon P. Nutzel, Nutley (in service); Robert E. Rich, Newark; Paul J. Strassberger, Belleville.

GLOUCESTER COUNTY

D. R. Brewster, Jr., M.D., Reporter

The *Gloucester County Medical Society* met February 20 at the Woodbury Country Club in Woodbury with Dr. Louis Collins presiding.

Dr. F. G. Wandall reported on the meeting of the Post-Graduate Committee held in Trenton. Rutgers University is willing to start a course of lectures for the benefit of the members of the Societies. There would be six lectures for the price of $250 to the County Society. It was voted by this society that we join with Camden County Society and contract for the lectures.

The Society has decided to sponsor a Blood Donor Service which is to be organized and directed by the Gloucester County Chapter of the Red Cross.

Drs. Tucker and Hawthorne of the Graduate School of Medicine in Philadelphia gave a very interesting illustrated lecture on the diagnosis and treatment of cancer of the esophagus.

Considering the raging blizzard of that night, we had a very excellent turnout.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting on March 4, at the Masonic Club in Jersey City, Dr. C. E. McNenney, presiding.

At this meeting, the Society went on record as endorsing the campaign of the American Cancer Society.

Dr. Ginsberg, chairman of committee on Post-Graduate Medical Education, announced a post-graduate course in medicine to be given at weekly intervals beginning on April 18 and ending on May 23, 1947.

Dr. J. L. Evans read the following nominations for 1948:

President, David I. Nalitt; Vice-President, P. A. D'Acierno; Secretary, Vincent P. Butler; Treasurer, Anthony J. Conty; and Reporter, Harry J. Perlberg; Board of Trustees, Sidney Chayes and E. J. Chapman; Board of Censors, J. L. Evans; Audit Committee, Frank Arndt; Publication Committee, R. S. Driscoll, J. C. Talty, N. L. Shulman, Edward Salmon; Delegate to State Nominating Committee, James F. Norton; Alternate to State Nominating Committee, J. Lawrence Evans; Committee on Constitution and By-Laws, S. I. Kooperstein; Election Committee, S. G. Scott, L. A. Schneider, J. A. McCarren, J. C. Talty, W. M. Doody, Samuel Schept, J. J. Danielson; Legislative Committee, S. G. Scott, J. J. Danielson, E. J. Connell; Maternal Welfare Committee, A. J. Walscheid, E. G. Waters, A. O. Largay; State Society's House of Delegates, T. McG. Brennock, A. W. Little, J. J. Ruvane, N. M. Alter, A. J. Conty, W. M. Doody, J. P. Donnelly, V. P. Butler, J. A. Botti, E. J. Daly, A. J. Walscheid, Walter Weber, G. W. Sinnott; Alternate Delegates, A. S. Goldsmith, D. D. Dougherty, E. M. Kiely, B. P. Potter, G. C. Lawsing, J. J. Scott, Ralph Doran, Frank Perlstein, W. T. Fifer, J. L. Hollywood.

A communication was read from Dr. David R. Atwell of Hoboken suggesting that an amendment be proposed to the effect that membership dues shall be non-exacting after the age of eighty years, and that should the proposed amendment be enacted, it shall not be retroactive.

A letter was read from the chairman and the director of Home Nursing, *American Red Cross,* describing revised courses in *Care of the Sick* and *Mother and Baby Care and Family Health.*

The following applicants were elected to membership: Dr. Frank W. Mahoney of Jersey City; and Drs. John P. Riordan and Elaine Weston of Arlington.

The scientific program opened with a talk on *Progress in Cancer Treatment* by Dr. Robert Hayward Kennedy, Attending Surgeon in Charge of Tumor Division of New York Post-Graduate Hospital. Dr. Kennedy predicted a coming era in medicine wherein neither surgery nor radiation therapy will be used extensively for the eradication of cancer, but in their stead, a systemic method of treatment. He emphasized the necessity for cancer-consciousness among physicians when dealing with *all* age periods and for *prompt* institution of therapeutic measures. Drs. Faison and Perlberg were discussants. Dr. Kennedy received a rising vote of thanks.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The February meeting of the *Monmouth County Medical Society* held at the Monmouth Memorial Hospital in Long Branch, was opened by the president, Dr. James Pregnall. *A Symposium on the Modern Treatment of Tuberculosis* was presented. The principal speaker was Dr. Benjamin P. Potter of the Jersey City Medical Center. Dr. Potter presented the differential diagnosis of tuberculosis and outlined the principles of treatment. His presentation was illustrated with case histories and slides of roentgenograms.

The second speaker was Dr. George McDonnell who presented two cases illustrating the value of rest and pneumothorax in the treatment. The progress of these patients was followed by slides made from serial x-rays.

Dr. A. Downey Osborn presented cases in which further treatment proved necessary. Thoracoplasty was discussed. Its limitations, indications and contraindications were considered.

Dr. Howard Burkhead was the last speaker on

the program. His paper dealt with the recent advances in chemotherapy in tuberculosis. The sulfons were quickly dismissed as being too dangerous. Streptomycin is still in the experimental stage and the final evaluation is not available at this time. Further investigation is necessary. Dr. Burkhead also presented the surgical therapy. It consists of removing the involved sections or entire lobes. The greatest danger is contralateral spread of the disease. The indications for surgery were listed and discussed.

Dr. Bornstein and Dr. Seagle were among those of the audience who offered further information about the treatment and diagnosis of tuberculosis. The papers were summarized and the discussion closed by Dr. Potter.

The business meeting followed this symposium. It was decided that the election meeting be held in March rather than in April. It was believed desirous to have the election of the officers before the state meeting in April. Dr. Holters of the nominating committee presented the nominations.

Dr. Colby of the Educational Committee presented a report on post-graduate education. Rutgers University will supply six men but the society will have to guarantee $250. A questionnaire will be sent to all members of the society in order to discover how many members are interested.

Dr. Victor Knapp questioned the necessity of an executive secretary. A motion was made that the society not engage an executive secretary. The motion was defeated.

The announcement of the Spring Formal Dinner Dance was made. On recommendation of the membership committee the following applicants were elected to full membership: Dr. Edward Dengrove of Interlaken and Dr. William D'Elia of Spring Lake. Dr. Louis De Simone of Asbury Park was elected to associate membership.

The annual dinner meeting and election of officers was held at Joseph's Restaurant, Eatontown, on March 26. Before dinner, the members of the society enjoyed a few minutes of sociability over cocktails. Directly after dinner the business of the evening was begun. Ballots were passed among the members with the names of those proposed by the nominating committee. Further nominations were accepted from the floor. The results of the elections were as follows:

President, Dr. Louis Albright; President-Elect, Dr. Frank Altshul; Assistant Secretary-Treasurer, Dr. Anthony DeVita; Reporter, Dr. Helen Jones; Board of Censors, Dr. C. C. Perrine; Executive Committee, Dr. Carlos Pons, Dr. Samuel Edelson and Dr. Victor Knapp; Delegates to State Convention, Dr. Robert MacKenzie, Dr. Stanley Wilkins, Dr. Stanley Nichols and Dr. George McDonnell; Alternate Delegates, Dr. Morton Trippe, Dr. William Koch, Dr. Ralph Woodruff, Dr. Norman Nathanson, Dr. Baer and Dr. Richard Demaree; Nominating Delegate, Dr. William Herrman; Alternate Nominating Delegate, Dr. Daniel Featherstone.

It was announced that the balloting on the proposed amendment to the constitution and by-laws of the Monmouth County Medical Society would take place at the next meeting. This amendment is printed in the bulletin.

Dr. Amerigo George of Long Branch, N. J., and Dr. Julius Toren of New Jersey State Hospital, Marlboro, N. J., were unanimously elected to full membership.

Dr. Nichols presented us with a few exceedingly important contemplations on the status of medical practice in reference to the public good and social medicine. The Society adopted the following resolution:

WHEREAS the recent National Election has provided a year or two of "breathing space" for the medical profession to make good medical services more available to all people in New Jersey at all income levels, particularly in low income families, and

WHEREAS it is essential that more effective means be provided at once to accomplish this goal, with the aid of our allied professions and all public and private agencies concerned with this outstanding problem, therefore

BE IT RESOLVED that, to accomplish this purpose, the President of The Medical Society of New Jersey appoint a Special State Society Committee for Medical Care (of seven of the most able members of the Society), to include five Past Presidents, to lay out a complete detailed plan for good medical care for every person in New Jersey,—the plan to be ready within ninety days; this Committe to have all facilities and staff of the Society placed at its disposal to expedite the study, and

BE IT FURTHER RESOLVED that for the use as soon as this plan is ready, the House of Delegates of the Medical Society of New Jersey include the sum of $20,000.00 in the budget for the coming year, and direct that it shall be efficiently used by the Public Relations Committee to employ a professional public relations expert to establish as promply as possible at State, and at the twenty-one County levels, a sound complete program, which will make available good medical services to all people in New Jersey, particularly in low income families, and

BE IT FURTHER RESOLVED that the Public Relations Committee, working with the Public Relations Committees of the County Medical Societies, shall create a State and County working relationship with the health professions, the governmental and private agencies, and the organizations representing the larger consumer groups, to meet this outstanding need in a manner that will convince the entire public of this State of the sincerity and ability of the medical profession to see that good medical services are made available to every person at any income level in this State, whenever such person shall make it known to any County Medical Society or the State Medical Society that good medical services are not available to them.

OCEAN COUNTY

H. Rinzler, M.D., Reporter

The March meeting of the *Ocean County Medical Society* was held in the form of the Society's annual dinner in honor of its Woman's Auxilary, at the Laurel-in-the-Pines, Lakewood, on March 15, at 7:00 p. m. Dr. Raymond A. Taylor, president of the Society, was master of ceremonies, and regular business was abandoned in favor of food and festivity.

Mrs. Carl Menge, president of the Woman's Auxiliary of the Ocean County Medical Society, spoke briefly, thanking Dr. Taylor and his colleagues and emphasizing the willingness of her group to assist and cooperate with the society in any way. Mrs. Frederick G. Wandall, of Clayton, president of the State Auxiliary, was also a guest and spoke of the larger problems confronting the ladies. In conclusion a few words were heard from Dr. Royal Schaaf of Newark, president-elect of The Medical Society of New Jersey, who recalled the fine growth of the Auxiliary in its short existence and pointed out the many ways in which it could be of assist ance to the local societies, especially in its rela tionship to the lay public.

Following the speakers, a vote of thanks was given to Dr. Adolph Towbin of Lakewood for his fine management of the dinner, and the party adjourned to the Burgundy Room to enjoy the dancing and floor show.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on February 18, 1947, at the Administration Building, Paterson, with our President, Dr. Harry Wolfson presiding.

The following applicant physicians were elected to membership: Dr. Louis Scovern and Dr. Paul Grossbard of Passaic; Dr. Benjamin Yorke, Paterson; Dr. Arnold Schleifer, Fairlawn, and Dr. William C. Gordon, Wanaque to Active Membership. Dr. Irving J. Selikoff, Dr. Frank A. De Dominicis, Dr. Nadhim E. Meer, Dr. Aaron Weiner, Dr. Andrew Sporer of Paterson and Dr. Anthony R. Garzieri of Totowa to Associate Membership.

Resolutions on the deaths of Dr. Howard L. Maps and Dr. Harry Jarmulowsky were unanimously adopted:

RESOLUTION
on the death of
Dr. HARRY JARMULOWSKY

Whereas: The members of the Passaic County Medical Society feel a deep and sincere regret in the passing of Dr. Harry Jarmulowsky, who for more than forty years practiced his profession faithfully, honorably and with a sympathetic understanding. After graduating from the Physicians and Surgeons College of Columbia University in 1900, he went abroad and studied at Kiel University. In 1906 in recognition of a thesis which he wrote upon Caesarian Section, the University of Kiel conferred upon him an honorary degree of Doctor.

After several years of practice in New York City, he came to Paterson in 1917, where he practiced his profession diligently until the day of his death. He was beloved by his patients and respected by physicians as a student of Medicine, an able physician and a friend to the sick. A man of vision and courage, he was an asset to the community.

Whereas: the Divine Creator, in His Infinite Wisdom, has seen fit to call unto Himself our respected Colleague and friend.

Be It Resolved: That the members of the Passaic County Medical Society deeply mourn the loss of our late colleague, Dr. Harry Jarmulowsky and express our heartfelt sympathy to his loyal and devoted wife, Mrs. Ruth G. Jarmulowsky and to his son, Alvin.

Be It Further Resolved: That this Resolution be spread in full upon the minutes of this meeting and a suitable copy thereof be presented to his family.

Signed:

David Shapiro, M.D.
J. Allen Yager, M.D.
Samuel L. Sloan, M.D.

RESOLUTION
on the death of
DR. HOWARD L. MAPS

Almighty God, in His infinite wisdom, saw fit to take from our midst our good friend and colleague, Dr. Howard L. Maps on January 18, 1947.

Dr. Maps was an able and conscientious practitioner in gynecology for many years. During this period he displayed a keen and deep understanding of the many patients under his care. This humane and kindly supervision of thousands of sufferers brought much physical and mental comfort to them.

His professional conduct and ability stamped him as an outstanding member of the medical profession and a credit to the Passaic County Medical Society.

Therefore Be It Resolved: That this Society deplores the loss of their fellow-member and extends its deepest sympathy to his family.

Signed:

Morris Joseph, M.D., Chairman
Samuel Ginsberg, M.D.
Fred Vosburgh, M.D.

Preceding the scientific session, Dr. Wayne Hall, Chairman of the Postgrauate Education Committee, addressed the members briefly on the graduate course offered by Rutgers University. The cost of six lectures will be $250 to the Society regardless of the number of men attending.

Dr. Hall also spoke of the Veterans Examination Plan for pension examination to be conducted in Passaic County, stating that preliminary teams have been set up at the hospitals but that the work will be spread as much as possible to include all physicians interested in doing the examinations.

He reported on the Centennial Celebration for the Program Committee,—A two day session, to be

held in May, with lectures at 4 and 8 p. m. plus a dinner on the second day.

For the scientific session, Dr. Wolfson introduced the speaker of the evening, DR. WILLIAM S. COLLENS, Diplomate of the American Board of Internal Medicine, who addressed the members on *Common Complications of Diabetes* and illustrated his paper with lantern slides.

SOMERSET COUNTY

William F. Jones, M.D., Reporter

The regular meeting of the *Somerset County Medical Society* was held at the Somerset Hospital on February 13, 1947. DR. JAMES YOUNG presided.

Minutes of the previous meeting were read and approved. The minutes of the executive meeting were read and approved.

Doctors Wender, Chase and Sanford were admitted to the membership having been approved by the Board of Censors and Executive Committee.

DR. DOUGLAS reported on the County Council of Social Agencies in relation to visiting nurses, and stated that said nurses did an excellent job and recommended the Society approve their work.

DR. R. HOWARD presented a very interesting talk on the subject of *Folic Acid.* He explained the history of the development of the material and showed motion pictures of its clinical use. The presentation and picture were very well received and appreciated by all. A rising vote of thanks was given to Dr. Howard for his excellent presentation.

UNION COUNTY

Edward G. Bourns, M.D., Reporter

The regular meeting of the *Union County Medical Society* was held on Wednesday, January 8, at St. Elizabeth Hospital, Elizabeth, with the president, DR. ELTON W. LANCE, in the chair. The plan suggested by the Union County Tuberculosis League to x-ray all patients on admission to general hospitals was discussed. Dr. Runnells spoke briefly on the results achieved in tuberculosis work in the past 40 years and particularly of the work accomplished in Union County. He stated that the advantages of routine admission x-rays in general hospitals would be worth the cost and that he felt sure this plan could be worked out satisfactorily. After a discussion from the floor on several phases of the plan, it was moved that the County Society approve the plan suggested by the Union County Tuberculosis League to x-ray all patients on admission to general hospitals and that the president appoint a committee to study the plan further with regard to equipment required, cost, etc. As announced in the December and January Bulletins, a discussion was held on the Medical-Surgical Plan. After a detailed discussion, it was moved that the County Society go on record as approving the Medical-Surgical Plan of New Jersey.

The following physicians were elected to membership in the Society: Dr. Anthony Bruno, Elizabeth; Dr. R. A. Hall, Westfield; Dr. J. C. Hanrahan, Elizabeth; Dr. Joseph Judd, Jr., Elizabeth; Dr. P. P. Leone, Elizabeth; Dr. W. E. Martin, Cranford; Dr. Sol Pollack, Union, and Dr. C. J. Sager, Roselle. New members present, Drs. Hanrahan, Judd, Leone and Martin, signed the Constitution and were introduced to the Society.

Dr. Wuester, chairman of the Cancer Committee, gave a report of the work being done not only in Union County but in the State. He informed the members of the availability of information through the office of the Union County Chapter of the American Cancer Society located in the office of the Union County Chapter of the American Cancer Society in the Elizabeth Court House where a competent executive secretary is on duty to answer questions on cancer. The secretary when called regarding examinations will ask the name of family physician, and refer patient to him. She will on request, contact the physicians and arrange appointments at convenience of the doctor in order that sufficient time may be given for thorough examination. A good educational program in Union County has been planned but is not complete at this time. A full report will be made at the next meeting. It was moved that the County Society go on record as favoring a complete physical examination by the family physician on all patients requesting this examination for the detection of cancer, said examination to be performed by appointment if possible so that sufficient time can be allocated for complete physical examination. It was also moved that the County Society approve the expenditure of $1,500.00 from the funds of the American Cancer Society through the Union County Chapter for the allocation of a radon fund for the purchase of radon emanation for treating indigent patients.

Dr. Lepree, chairman, Union Plan for Veterans Medical Care Committee, on request gave the report made to the Executive Committee on January 6, which was approved at that time. He reported on meetings held by his committee to study the suggested plan of the State Society relative to the setting up of examining units for veterans with disability claims. The State Society has agreed to help the Veterans Administration clear the large number of veterans now awaiting rating examinations and has asked each county society to establish the clinics. These clinics must be in hospitals in order to centralize the work and to have available during clinic hours facilities of x-ray and laboratory. Every hospital in the country has been contacted and one is ready to start, another will be ready shortly. The International Business Machines Corp. has been contacted by the N. J. Consolidated Plan (The Medical Society of New Jersey) to do all the records and bookkeeping. Clerical work, etc., that will be needed can be done in the Executive Offices. Every member of the Society will be contacted to participate and the examinations will be done by rotating teams. He also announced that Dr. Lance had appointed the members of the Committee, Drs. Lepree, Abel, Kreutz, Lyerly, Foster, Orton and Yorke to form the first Board of Trustees to the Union Plan. It was moved that the Union County Medical Society accept the report of the Executive Committee, that the Plan be adopted and that $1000.00 be loaned without interest for the formation of the Corporation of the Union Plan for Veterans Medical Care.

MRS. LODOVICO MANCUSI-UNGARO, 1947-48 PRESIDENT

Frances Mancusi-Ungaro, of Newark and West End, N. J., is the daughter of the late Dr. James Quarles Chambers, who was one of the outstanding diagnosticians of Kansas



City, and Mrs. Chambers. Her brother, Dr. James Quarles Chambers, Jr., recently honorably discharged lieutenant-colonel of the Medical Corps of the Army of the United States, served 33 months in the Pacific theatre and is the fourth generation of physicians in the United States. The first Dr. James Chambers with a degree in medicine from the University of Glasgow in 1783 came to America; was ordained an Episcopalian minister in 1786, and settled in Virginia where he practiced the two professions, as was often the custom in those days. His daughter, Margaret, married Gerard C. Brandon, one of the first governors of Mississippi.

With an A. B. in the classics from Smith, Mrs. Mancusi-Ungaro hesitated between studying medicine and voice, meanwhile qualifying as x-ray technician under Dr. Ira Lockwood of Kansas City. Using this technical knowledge as a means of livelihood she studied voice under William Alling of New York and bel canto under Anna Tripputi of Newark. In 1929 she married Dr. Lodovico Mancusi-Ungaro, the ninth generation of physicians in his family. They have four children: Giovanna, a senior at Kent Place School in Summit, Pier-Lodovico, a third form student at Newark Academy, Mario and Diana.

Mrs. Mancusi-Ungaro organized and directed the drive in the first ward for the Woman's Division of the Newark Chapter of the American Red Cross under Mrs. Henry Barkhorn for three years. She was elected president of the College Woman's Club of Essex County May 1946. She is a member of the board of managers of the Home for Respectable Aged Women. She has served the woman's Auxiliary to the Essex County Medical Society in many capacities, becoming president in 1943. She was one of the organizers of the Woman's Division of the Newark Safety Council as a special representative for the Woman's Auxiliary to The Medical Society of New Jersey and served on that Executive Board for two years. She has served as chairman of publicity for the Woman's Auxiliary to The Medical Society of New Jersey from 1943 to 1946; as first vice-president 1945-1946; as president-elect 1946-1947. Other clubs include the Smith Club of the Oranges and the Newark Garden Club.

ACCEPTANCE OF THE GAVEL

MRS. LODOVICO MANCUSI-UNGARO

Mrs. Wandall, you are to be congratulated upon filling, with dignity and charm, the exacting role of President of the Woman's Auxiliary to The Medical Society of New Jersey. Anything which I may accomplish during my regime will be the direct outgrowth of the fine work you and your predecessors have done.

When I took office during the war as President of my County Auxiliary, I said that unless we could be of service to the medical profession we had no right to exist. Today the urgency of war is no longer with us, but the questions of the peacetable seem unending. Not the least of these are the many problems in the field of health education in which we, as women and as doctors' wives, should take a leading part, if we are to justify our existence as other than a social organization.

The Medical Society too has recognized that we can be of value to them and have included

us in their planning. Dare we stand idly by while groups other than ours divert the solutions of health problems to their own interests? We are linked by sacred vows to the noblest of the professions, and for this reason should be proud to dedicate ourselves to, and to work for, its ideals.

I am keenly aware of my own inadequacies for this high honor and grave responsibility. I shall need and I want the cooperation of all of you, that through our united efforts and constructive deeds we may prove ourselves worthy handmaidens of the disciples of Hippocrates, and assume our rightful leadership among women's groups in health education.

In December, at the National Conference, we were told that the leadership of the Auxiliary was to be undertaken with great seriousness, and that we were to prepare ourselves to the best of our abilities. This I have tried to do.

I am here to help each of you, officers, chairmen, and county presidents, whenever I can. You are free at all times to call on me, and I shall give earnest consideration to your problems, and try to make things run smoothly.

To be of service to the component counties, the Executive Board of a state organization must function far enough in advance to set standards and to be of use in planning county activity. It is therefore vital to our efficiency that, if this Board approve, we hold an auxiliary workshop, to which all state and county officers and chairmen must come or send a representative. To this workshop, would be invited key committee men of the Medical Society, to present the viewpoints they would like stressed in the coming year.

In addition, we have in mind several ideas that may enable us to assume leadership in health education among women's groups in the state, ideas which will be presented to you by my chairmen.

With the work that lies ahead, we have no time for petty factualism. I call upon each of you to approach this year with the idea of training yourself to be a leader in the problems of health education: to study the problems of your county; to school yourself so that when representative women are talked about for local, county or state committees on matters of public health, your name is among the first mentioned.

It has been my thought that a joint meeting of the outgoing and the incoming Executive Boards would do much to foster the feeling of continuity of our organization. I, as each of you, am the keeper of my position for but a year. It is our obligation to act impartially, to uphold the accomplishments of our predecessor, and assist our successor in profiting by our mistakes, in order that the prestige of the organization we serve increase.

TEN POINT PROGRAM

Mrs. Lodovico Mancusi-Ungaro

1. Promote friendliness among the wives of physicians.
2. Increase Auxiliary membership.
3. Organize unorganized counties.
4. Assist The Medical Society of New Jersey at all times when requested.
5. To Promote Hygeia.
6. Actively support all health movements endorsed by The Medical Society of New Jersey.
7. Promulgate favorable publicity for physicians through all media of communication.
8. Coordinate and integrate the functioning of the component Auxiliary committees with the corresponding committees of The Medical Society of New Jersey by means of a workshop once a year.
9. See that our members know the stand of all legislators on health questions, and that analyses of pending legislation be distributed effectively.
10. Assume leadership among the women's groups of New Jersey in health education.

AMERICAN MEDICAL ASSOCIATION MEETING

In a few more weeks the members of the Woman's Auxiliary to the American Medical Association will be arriving in Atlantic City, for their Annual Convention, June 9-13.

Have you made your reservation? It not, send your request at once to Dr. Robert A. Bradley, Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City.

FINAL MESSAGE OF MRS. F. G. WANDALL, 1946-47 PRESIDENT

This, my last message as President, extends heartfelt gratitude to the members of the Auxiliary and the Medical Society for a year of faithful cooperation in all our fields of endeavor.

We did not attempt objectives which we could not accomplish, nor did we set too many goals, thus dividing our strength. Rather, we picked up the yard stick where it was laid down by our predecessors, and moved on from there, gradually widening the pattern and gathering in the loose ends, in order to give the allover picture more continuity and strength.

Steering the course of the Auxiliary was a privilege I shall remember always. The many friends I made, the ready willingness of every organized county to help carry out the state program, and to serve the Medical Society when special duties were assigned them, the sympathetic understanding of my Advisory Councils in the Auxiliary and the Medical Society, made me aware of the confidence which had been placed in me when I was elected to serve as President.

I have tried, by being well informed, and by my carriage, to be worthy of the title bestowed upon me, remembering ever to hold the torch high, lighting the way for those who follow in the path.

To our incoming President, Mrs. Lodovico Mancusi-Ungaro, I extend congratulations. I know she will have the same cooperation and consideration in the coming year that it was my good fortune to have had during my administration.

And so, to link the days that were with the days that are—

"As we fade away like the stars in the morning,
Losing their light in the glorious sun,
May we, like them, depart gently and lovingly,
Remembered by what we have done."

EXECUTIVE BOARD MEETING

Mrs. Robert B. Walker, Chairman, Press and Publicity

The third Executive Board meeting of the Woman's Auxiliary to the Medical Society of New Jersey was held Monday, March 10, 1947, at the State Society Headquarters. Twenty members attended, including five county presidents. Mrs. Frederick G. Wandall presided. She asks that the Auxiliary members throughout the state, make an effort to attend the Annual Convention in Atlantic City, April 22-24. The Finance Committee passed a motion that, due to the tremendous amount of correspondence, the State President be provided with a part time paid secretary. Reports of all State Chairmen and County Presidents were heard.

Following the morning session, Dr. Samuel Blaugrund, Public Relations Chairman of the Mercer County Medical Society, spoke on "Future Aspects of Public Relations". Dr. Blaugrund said in part, "There are three forces forming the basic interest in public health; the oldest, the medical profession, government forces and lay groups. All of these are expanding. The lay groups are public spirited individuals who have become interested in public health. However, government agencies, the medical profession and public lay groups must cooperate in order to accomplish their objectives. All lay groups should consult with Medical Societies, before having health programs.

"What should be done to improve health in the schools of New Jersey? There should be a complete health program, whose goal is optimal health for all. This program should be constructed by the New Jersey physicians. The importance and necessity of other social and welfare groups is recognized, but the principal responsibility is that of the medical profession.

"The Woman's Auxiliary can assist in health programs, by first educating themselves on all health problems before approaching the public. Interest in nursing homes and day nurseries in your community is important, as in many instances they are not conducted to insure the good health and well being of their charges.

"The Auxiliaries should not be involved in too many things. Take one and follow it through to the end, have something worthwhile to present at the end of the year. With the permission of the Medical Society, take part in the health of the county and be a force for good in the community."

Following Dr. Blaugrund's talk, luncheon was served at the Carteret Club.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **May, 1947** **No. 5**

TUBERCULOSIS among medical students and nurses remains a localized point of resistance to generally effective control measures. This is an anomalous situation when one considers that tuberculin tests, the use of X-ray in diagnosis and the principles of isolation technique are being taught and demonstrated to these students while apparently not fully utilized for their protection. This situation is a professional challenge to schools of medicine and nursing. Society can ill afford to lose the usefulness of these carefully chosen and highly trained young people as they prepare for or begin what should be a life of service in their profession.

PULMONARY TUBERCULOSIS IN HARVARD MEDICAL STUDENTS

Despite a marked fall in the morbidity and mortality due to pulmonary tuberculosis among the general population and despite advances in its early diagnosis and treatment, tuberculous infection of the lung remains the most serious medical problem that confronts the medical student. Although for more than a century European clinicians had been aware of an apparent high incidence of pulmonary tuberculosis among medical students, a similar high incidence was overlooked in American medical schools until 1930. Since that date several surveys have shown that rates depend somewhat on the geographical origin of the student body, the location of the school, the diagnostic criteria and the care with which the survey was conducted. The most carefully conducted surveys report an incidence in the neighborhood of one or two per cent.

The medical histories of 24 classes of the Harvard Medical School, beginning with the class of 1926, were studied. All available clinical information, including X-ray films as well as sanatorium reports and personal communications, was reviewed in each case.

In all cases considered in this study chest films showed either the appearance of a lesion not previously present or extension of a previously known lesion. Calcified primary complexes, however extensive, thickened apical caps, blunted costophrenic angles and small apparently obsolete nodules were not considered clinically significant, and were not included. Supporting clinical evidence for activity included at least one of the following symptoms: cough, hemoptysis, fever, anorexia, weight loss and general malaise. In many cases acid-fast bacilli were demonstrated.

The tuberculin-test figures were derived from the original work sheets of the routine tuberculin surveys. The two-test-dose, intradermal method was used, the results being read in 48 hours. Induration of at least 5mm. in diameter was used as the sole criterion of a positive test. Slightly over 30 per cent of students entering Harvard Medical School as nonreactors became tuberculin reactors before graduation.

Of 3,160 students from 1922 through 1945, it is known that 44 developed pulmonary tuberculosis—an over-all incidence of 1.4 per cent. Because of the incomplete case-finding program prior to 1936, however, undoubtedly many cases went unrecognized. Classes in which no organized case-finding program was conducted, had an incidence of 0.9 per cent. In the group which had routine chest films and tuberculin tests on admission and in which many students had chest films in their fourth year, the incidence was 1.1 per cent. In classes in which routine admission chest X-ray examination and tuberculin tests were followed by annual re-examination of nonreactors by means of the tuberculin test, and of most positive reactors by X-ray, the rate was 2.2 per cent.

An incidence almost three times that known

before the introduction of a case-finding program is in accordance with the experience of other medical schools.

The duration of disability caused by the pulmonary lesion was closely correlated with the severity of the lesion at the time of its discovery. Students with major lesions have had prolonged periods of disability and several failed to complete their medical education. Students whose lesions were detected by the appearance of symptoms nearly always showed major lesions, whereas just as regularly students whose lesions were detected by routine examination showed minor lesions. Only about half the students with minor lesions required sanatorium care. The average stay in these cases was 14 months.

The effectiveness of routine examination in the detection of early lesions makes frequent examination mandatory. The case-finding program, consisting of routine tuberculin tests and chest X-ray examination on entry and at graduation, has been progressively modified to the semiannual examination. During the period of annual examination, a large proportion of the lesions became symptomatic, and were thereby detected, before the time of re-examination. In addition, at least three students developed major lesions within a year of having been found to be nonreactors to the annual tuberculin test.

It is believed that six months represents the maximum interval that should be allowed to elapse between routine X-ray examination of tuberculin reactors aud tuberculin tests of nonreactors. When students previously nonreactors become reactors in the semiannual examination, X-ray examination of the chest should probably be done every six weeks for six months, and every three months for the remainder of the year. The rapidity of progression of the disease in medical students is such that many lesions become symptomatically evident, and are thereby detected, in intervals between routine examinations made only annually.

The adoption of a program in which surveys are made at intervals more frequent than once a year has led to the elimination of almost all symptom-detected cases and of all major lesions. It is believed that a semiannual examination represents the maximum interval for routine re-examination by X-ray or tuberculin tests not only for medical students but also for nurses and interns.

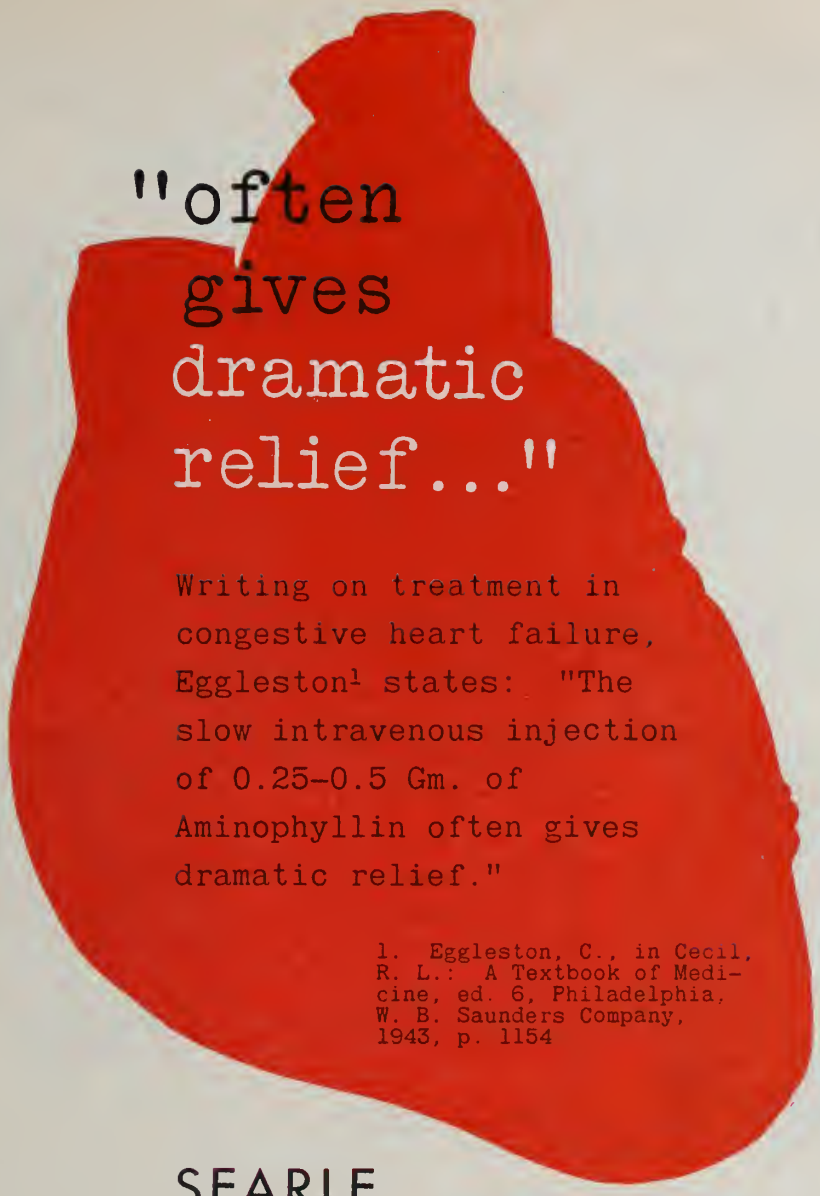
Although the number of cases of pulmonary tuberculosis discovered in the last two years of the medical-school course was four times as great as the number developing in the first two years, the incidence of acquisition of tuberculosis infection as determined by the tuberculin test was about the same (12 or 13 per cent annually) for each academic year. This constant annual attack rate suggests that factors other than opportunity for infection are responsible for the fourfold increase in cases of pulmonary tuberculosis during clinical training.

Pulmonary Tuberculosis in Harvard Medical Students, Henry P. Brean, M.D., and Lewis W. Kane, M.D., The New England Journal of Medicine, September 5, 1946.

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1. Eggleston, C., in Cecil, R. L.: A Textbook of Medicine, ed. 6, Philadelphia, W. B. Saunders Company, 1943, p. 1154

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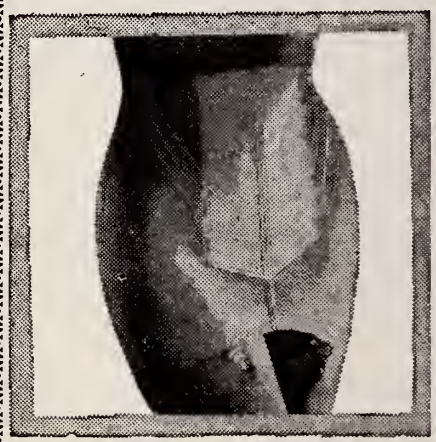
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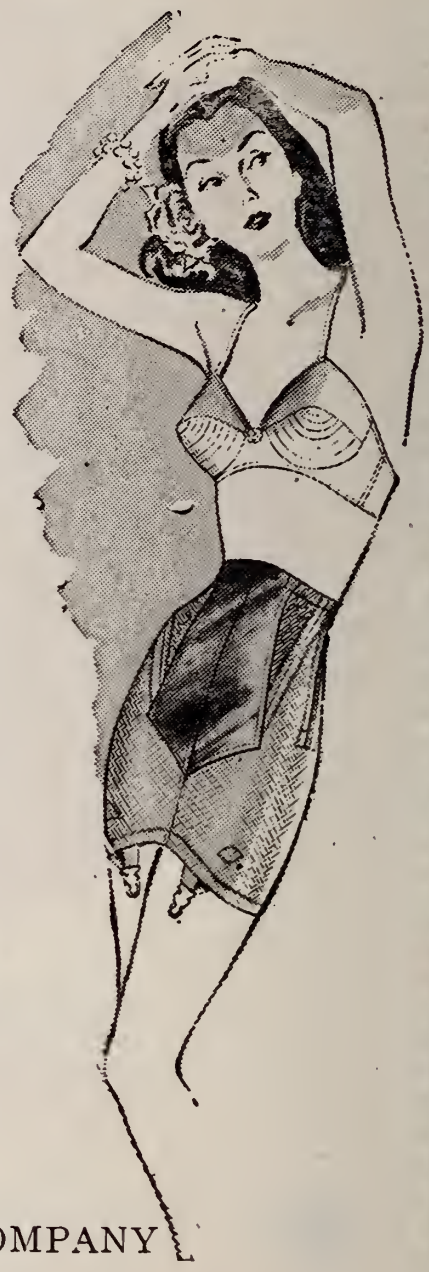
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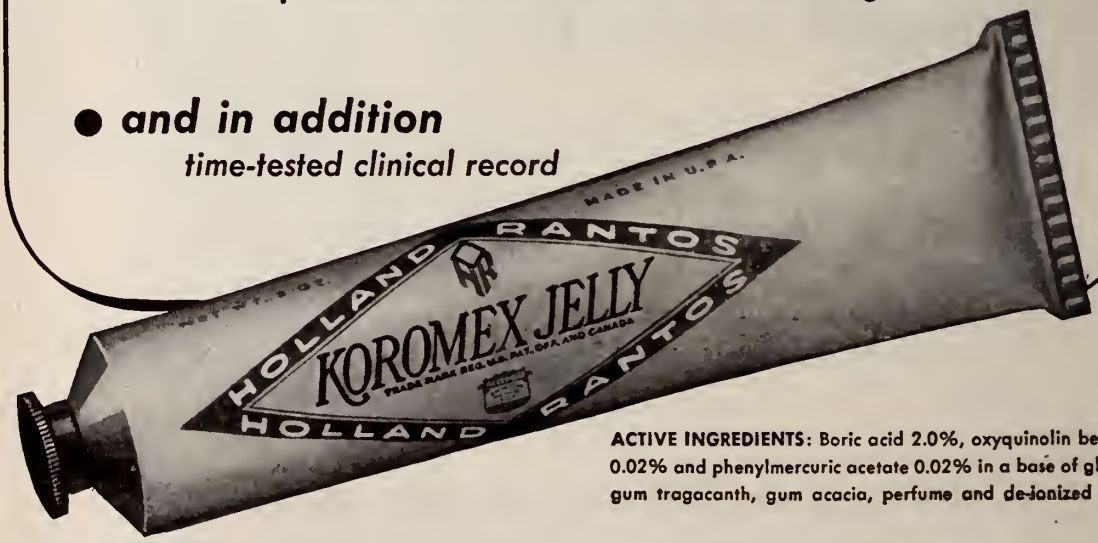
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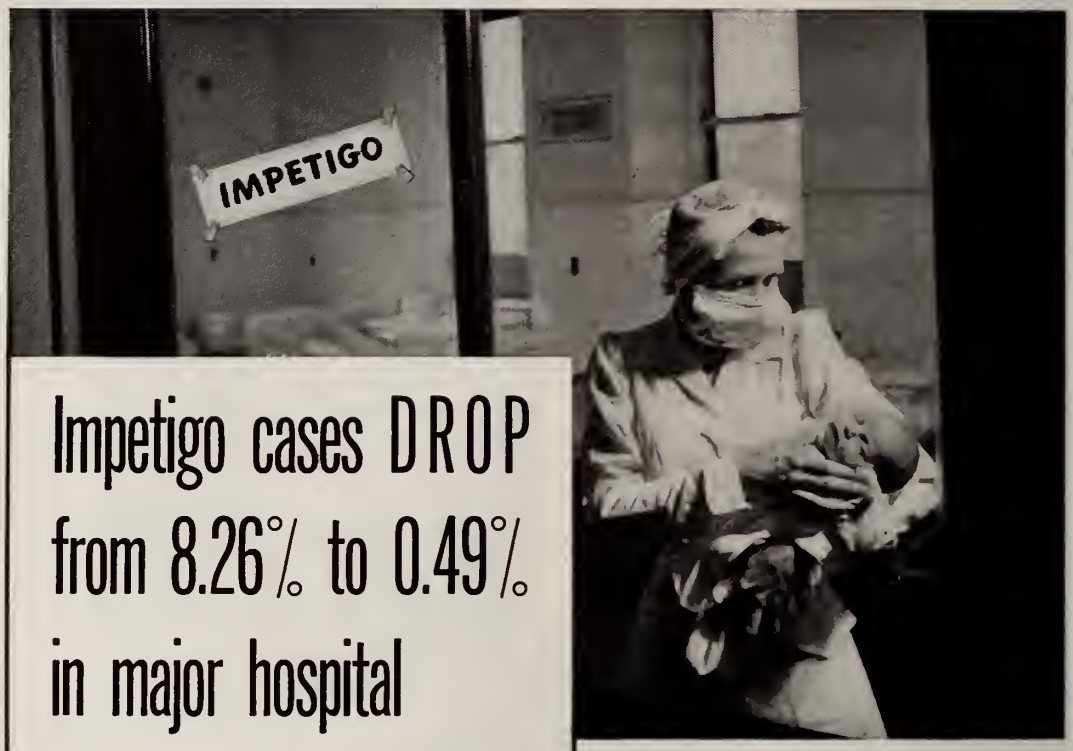
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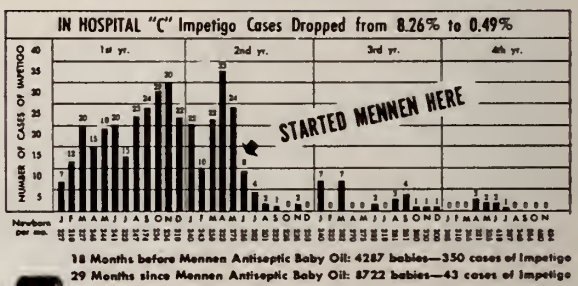
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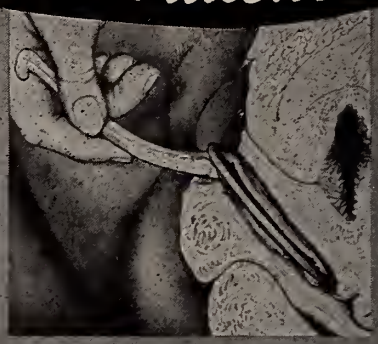
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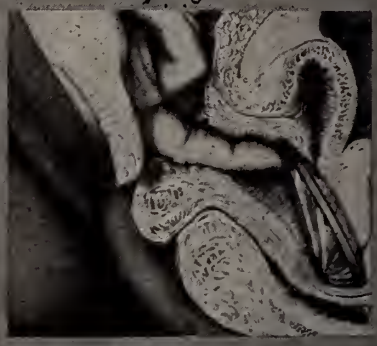
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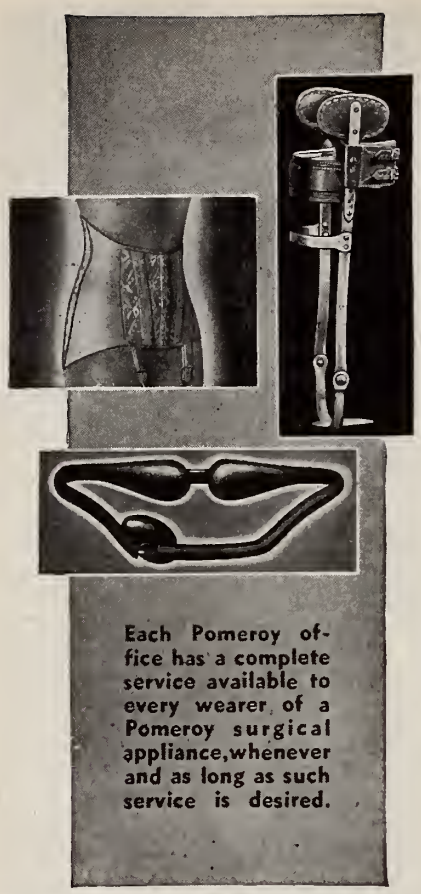
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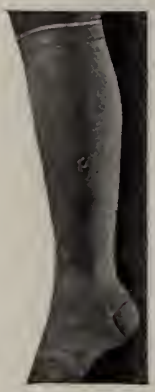
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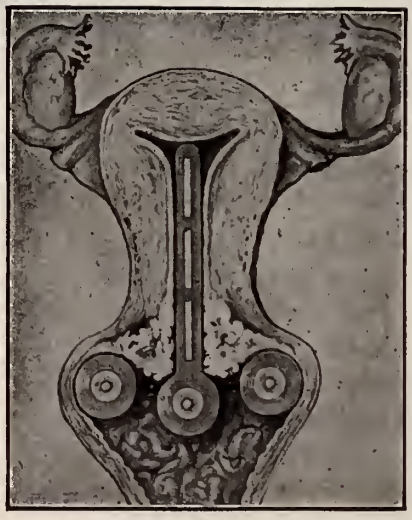
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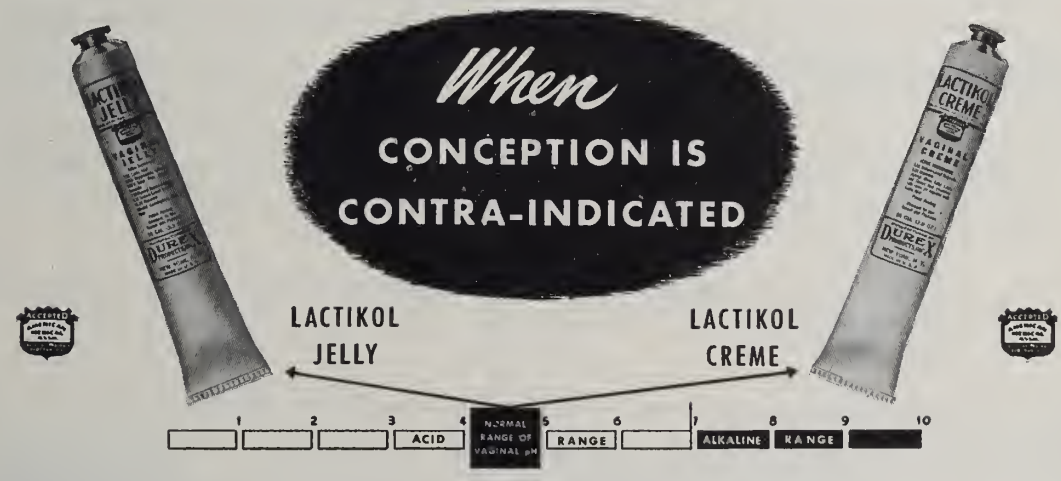
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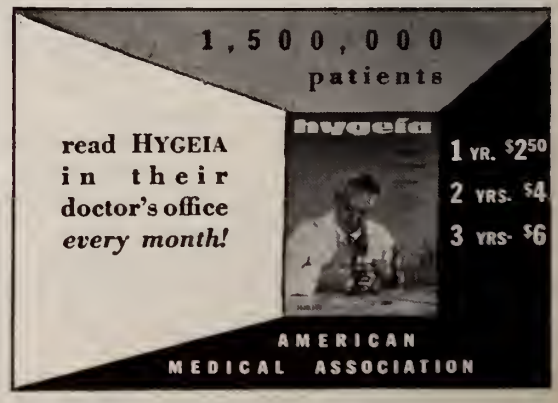
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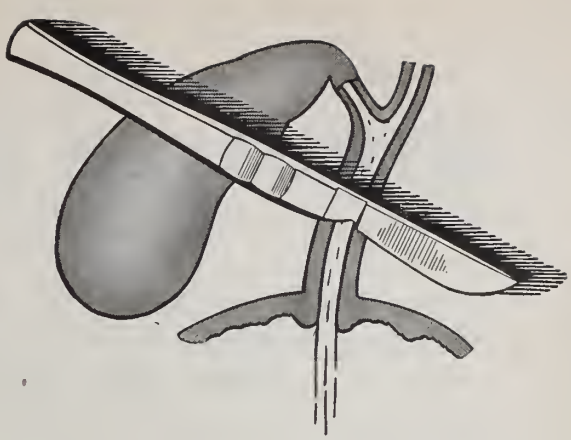
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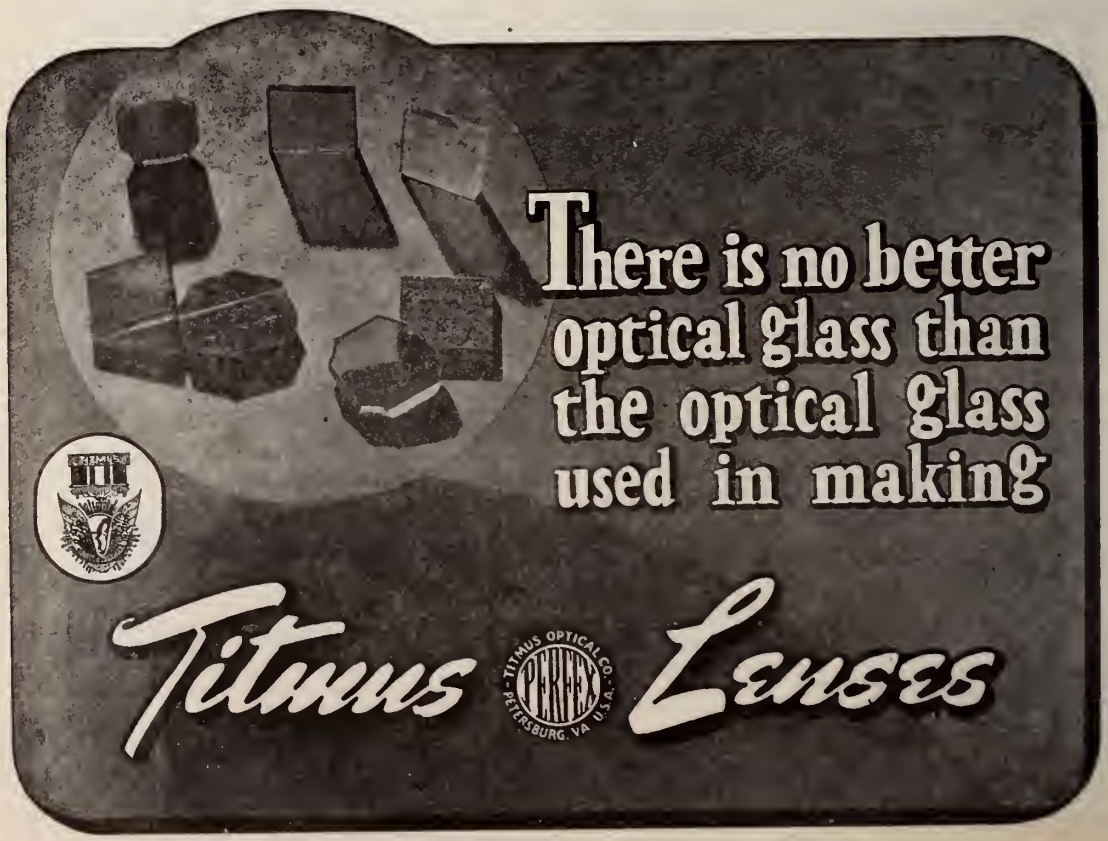
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CLYMONT MACARTHUR, *Chairman*.....Newark
SAMUEL J. LLOYD, *Secretary*.....Trenton

Radiology

HARRY R. BRINDLE, *Chairman*.....Asbury Park
RAPHAEL POMERANZ, *Secretary*.....Newark

Gastro-Enterology and Proctology

SIGURD W. JOHNSEN, *Chairman*.....Passaic
THEODORE S. HEINEKEN, *Secretary*.....Bloomfield

Pediatrics

ROBERT E. JENNINGS, *Chairman*.....East Orange
ISRAEL J. WOLF, *Secretary*.....Paterson

Obstetrics and Gynecology

RAYMOND T. POTTER, *Chairman*.....East Orange
JOSEPH P. DONNELLY, *Secretary*.....Jersey City

Eye, Ear, Nose and Throat

JOHN P. BRENNAN, *Chairman*.....Camden
ALBERTOS M. K. MALDEIS, *Secretary*.....Camden

CO-OPERATING AGENCIES

N. J. State Department of Institutions and Agencies

SANFORD BATES, LL.D., *Commissioner*

State House Office Building, Trenton 8, N. J.
Tel. 2-2131, Ext. 737

N. J. State Department of Public Instruction

WILSON G. GUTHRIE, M.D., *Director of Health, Safety and Physical Education*

Room 1302, 28 W. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 230

American Cancer Society, New Jersey Division, Inc.
L. S. SNEGIREFF, *Medical Director*
790 Broad St., Newark 2, N. J.
Tel. MItchell 2-4288

N. J. State Crippled Children's Commission
HARRY BACHARACH, *Director*
Room 732, 143 E. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 8174

N. J. Rehabilitation Commission
EDWARD A. STILES, *Program Director*
Room 735, 143 E. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 527

N. J. State Board of Children's Guardians
JOSEPH E. ALLOWAY, *Executive Director*
163 W. Hanover St., Trenton 8, N. J.
Tel. 2-2131, Ext. 308

N. J. State Board of Medical Examiners
EARL S. HALLINGER, M.D., *Secretary*
Room 1101, 28 W. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 272

N. J. State Department of Motor Vehicles
ARTHUR W. MAGEE, *Commissioner*
State House Office Building, Trenton 8, N. J.
Tel. 2-2131, Ext. 208

N. J. State Department of Health
J. LYNN MAHAFFEY, M.D., *Director of Health*
Room 232, State House, Trenton 8, N. J.
Tel. 2-2131, Ext. 541

N. J. State Nurses Association
MISS WILKIE HUGHES, R.N., *General Secretary*
Room 1112, 17 Academy St., Newark 2, N. J.
Tel. MArket 3-6361

N. J. Hospital Association
MR. F. HAROLD JOHNSTON, *Executive Secretary*
180 Somerset St., New Brunswick, N. J.
Tel. 2-8200

N. J. Pharmaceutical Association
JOHN J. DEBUS, *Executive Secretary*
Room 318, 28 W. State St., Trenton 8, N. J.
Tel. 5596

N. J. State Dental Society
JOHN G. CARR, D.D.S., *Executive Secretary*
223 E. Hanover St., Trenton 8, N. J.
Tel. 5084

N. J. Health Officers' Association
WILLIAM C. BLAKE, *Secretary*
Thomson Hall, Princeton, N. J.
Tel. 1005

N. J. Health and Sanitary Association
MR. JOHN HALL, *Executive Secretary*
3 Morris St., Freehold, N. J.
Tel. 8-0410 M

STANDING COMMITTEES

Meetings at the call of the Chairmen

Finance and Budget

DAVID B. ALLMAN, *Chairman* (1953) .....Atlantic City
HERSCHEL PETTIT (1948) .....Ocean City
WILLIAM F. COSTELLO (1949) .....Dover
LUKE A. MULLIGAN (1950) .....Leonia
L. SAMUEL SICA (1951) .....Trenton
ANTHONY J. CONTY (1952) .....Union City
GEORGE J. YOUNG, *Ex-Officio* .....Morristown

Medical Defense and Insurance

J. WALLACE HURFF, *Chairman* (1950) .....Newark
ROBERT L. McKIERNAN (1948) .....New Brunswick
WAYNE W. HALL (1949) .....Paterson
ARTHUR J. GANLEY (1949) .....East Orange
GEORGE T. TRACY (1950) .....Beverly

Publication

HENRY C. BARKHORN, *Chairman* (1948) .....Newark
LEWIS W. BROWN (1949) .....Newark
J. LAWRENCE EVANS (1950) .....Woodcliff
ROYAL A. SCHAAF, *Ex-Officio* .....Newark
EARL LEROY WOOD, *Ex-Officio* .....Newark

Scientific Work

First District—JOHN W. GRAY (1949) .....Newark
Second District—WM. W. MAVER, *Chm.* (1950)...Jersey City
Third District—PATRICK H. CORRIGAN (1951).....Trenton
Fourth District—S. EMLEN STOKES (1952).....Moorestown
Fifth District—HAROLD S. DAVIDSON (1948)....Atlantic City
GEORGE GINSBERG (1948) .....Hoboken
JOHN H. ROWLAND (1949) .....New Brunswick

Honorary Membership

E. ZEH HAWKES, *Chairman* (1949) .....Newark
SPENCER T. SNEDECOR (1948) .....Hackensack
RALPH K. HOLLINSHED (1950) .....Westville

Woman's Auxiliary

WILLIAM E. DODD, *Chairman* (1950) .....Beach Haven
HAMMELL P. SHIPPS (1948) .....Delaneo
L. SAMUEL SICA (1948) .....Trenton
ILY R. BEIR (1949) .....Atlantic City
SAMUEL BLAUGRUND (1950) .....Trenton

Post-Graduate Education

HENRY B. DECKER, *Chairman* (1949) .....Camden
ALBERT W. PIGOTT (1948) .....Skillman
SAMUEL A. COSGROVE (1949) .....Jersey City
ERNEST F. PURCELL (1950) .....Trenton
STUART Z. HAWKES (1950) .....Newark
WILLIAM F. COSTELLO .....Dover

Annual Meeting

HARROLD A. MURRAY, *Chairman* (1949) .....Newark
JOHN W. GRAY (1948) .....Newark
JOHANNES F. PESSEL (1949) .....Trenton
CLARENCE L. ANDREWS (1950) .....Atlantic City
FRANCIS M. CLARKE (1950) .....New Brunswick

Scientific Program

FRANCIS M. CLARKE, *Chairman* .....New Brunswick
CHARLES D. DRISCOLL .....West Collingswood
CLYMONT MACARTHUR .....Newark

WELFARE COMMITTEE

Meetings in Trenton at 2:00 P. M. on September 14, December 14 and March 7

VINCENT P. BUTLER, *Chairman* .....Jersey City
ROYAL A. SCHAAF, *Ex-Officio* .....Newark
EARL LEROY WOOD, *Ex-Officio* .....Newark
DAVID B. ALLMAN (Atlantic County) .....Atlantic City
EDWARD H. GUION .....Pleasantville
D. WARD SCANLAN .....Atlantic City
JOHN L. OLPP (Bergen County).....Englewood
HARLAND C. ESSERTIER .....Ridgewood
PAUL R. SPARKS (Burlington County) .....Burlington
R. WINFIELD BETTS .....Medford
WILLIAM E. BRAY .....Pemberton
ARTHUR G. PRATT (Camden County) .....Camden
H. WESLEY JACK .....Camden
EDWARD A. Y. SCHELLENGER .....Camden
MILLARD C. CRYDER (Cape May) ....Cape May Court House
ALDRICH C. CROWE .....Ocean City
SAMUEL B. HUGHES .....Wildwood
CHARLES CUNNINGHAM, JR. (Cumberland County)...Vineland
ALBERT B. KUMP .....Bridgeton
MARCUS H. GREIFINGER (Essex County) .....Newark
THOMAS W. HARVEY .....Orange
HARROLD A. MURRAY .....Newark
J. WALLACE HURFF .....Newark
HARRY N. COMANDO .....Newark
WENDELL J. BURKETT (Gloucester County) .....Pitman
CHESTER I. ULMER .....Gibbstown
J. LAWRENCE EVANS (Hudson County) .....Woodcliff
BERTHOLD S. POLLAK .....Jersey City
HUGH H. TYNDALL .....Wechawken
PHILIP W. BAKER (Hunterdon County) .....High Bridge
BARCLAY S. FUHRMANN .....Flemington
SAMUEL BLAUGRUND (Mercer County) .....Trenton
L. SAMUEL SICA .....Trenton
WALTER E. D'ARCY .....Trenton
RALPH J. FAULKINGHAM (Middlesex County)..New Brunswick
JOHN H. ROWLAND .....New Brunswick
C. BYRON BLAISDELL (Monmouth County).....Long Branch
STANLEY NICHOLS .....Long Branch
LOUIS F. ALBRIGHT .....Spring Lake
GEORGE B. EMORY, JR. (Morris County).....Morristown
SALVATORE GIORDANO .....Morristown
GEORGE L. NICOLL .....Succasunna
RAYMOND A. TAYLOR (Ocean County) .....Lakewood
CARMINE L. PECORA .....Toms River

ADOLPH TOWBIN ..... Lakewood
HOMER H. CHERRY (Passaic County) ..... Paterson
H. HALE HOLLINGSWORTH ..... Clifton
MORRIS JOSEPH ..... Passaic
HARRY F. SUTER (Salem County) ..... Penns Grove
FRANK L. PERRY ..... Woodstown
J. MALLORY CARLISLE (Union County) ..... Westfield
FREDERICK W. LATHROP ..... Plainfield
HERSCHEL S. MURPHY ..... Roselle
THOMAS J. WALSH ..... Elizabeth
WATSON B. MORRIS ..... Springfield
RALPH M. L. BUCHANAN (Warren County) ..... Phillipsburg
WILLIAM H. VARNEY ..... Washington

Consultants

MR. JOHN J. DEBUS (Pharmaceutical Association) ... Trenton
EMIL FRANKEL, Ph.D. (Institutions and Agencies) .... Trenton
EARL S. HALLINGER (Medical Examiners) ..... Trenton
MR. WILLIAM H. MACDONALD (Health) ..... Trenton
FREDERIC J. QUIGLEY (Legislation) ..... Union City

SUBCOMMITTEES TO THE WELFARE COMMITTEE

Meetings in Trenton at 11:00 A. M. on September 14, December 14 and March 7

Legislation

BERTHOLD S. POLLAK, *Chairman* ..... Jersey City
WENDELL J. BURKETT, *Vice-Chairman* ..... Pitman
J. WALLACE HURFF ..... Newark
THOMAS J. WALSH ..... Elizabeth
CHARLES H. MITCHELL ..... Trenton
FREDERICK S. TABER ..... New Brunswick
SAMUEL ALEXANDER ..... Park Ridge
FREDERIC J. QUIGLEY, *Executive Secretary* ..... Union City

Medical Practice

HERSCHEL S. MURPHY, *Chairman* ..... Roselle
J. MALLORY CARLISLE ..... Westfield
ANDREW C. RUOFF ..... Union City
WILLIAM K. HARRYMAN ..... Hackensack
WALTER E. D'ARCY ..... Trenton
CHESTER I. ULMER ..... Gibbstown
GEORGE BLACKBURNE ..... Newark
ASHER YAGUDA ..... Newark
HAROLD G. WALKER ..... Wyckoff
W. JAMES MARQUIS ..... East Orange
BROR S. TROEDSSON ..... Orange
EARL H. SNAVELY ..... Newark

Public Health

SAMUEL BLAUGRUND, *Chairman* ..... Trenton
HARROLD A. MURRAY, *Vice-Chairman* ..... Newark
ABRAHAM E. JAFFIN ..... Jersey City
ROBERT A. MACKENZIE ..... Asbury Park
ELBERT S. SHERMAN ..... Newark
HENRY A. COTTON, JR. ..... Trenton
HAROLD F. TIDWELL ..... West New York
ROBERT L. MCKIERNAN ..... New Brunswick
CHRISTIAN P. SEGARD ..... Leonia
WILLIAM O. WUESTER ..... Hillside
H. EUGENE READING ..... Paterson
S. WILLIAM KALB ..... Newark
JEROME KAUFMAN ..... Newark
RALPH K. HOLLINSHED ..... Westville
STANLEY NICHOLS ..... Long Branch
C. BYRON BLAISDELL ..... Long Branch
JAMES O. HILL ..... Newark

Consultants

DANIEL BERGSMA (Health) ..... Trenton
JULIUS LEVY (Maternal and Child Health) ..... Trenton
MR. WILLIAM H. MACDONALD (Health) ..... Trenton
EMIL FRANKEL, Ph.D. (Institutions and Agencies) .. Trenton
MR. JOHN J. DEBUS (Pharmaceutical) ..... Trenton
MRS. STEPHEN W. WATERBURY (Welfare Council) ... Hillside
MARY M. MUCKLEY (Nurses) ..... Fairlawn
ARTHUR B. PEACOCK (Board of Health) ..... Moorestown

Public Relations

L. SAMUEL SICA, *Chairman* ..... Trenton
NORMAN M. SCOTT ..... Newark
HENRY A. DAVIDSON ..... Flemington

ADVISORY COMMITTEES TO THE SUBCOMMITTEE ON PUBLIC HEALTH

Meetings at the call of the Chairmen

Adult Disease Control

RALPH K. HOLLINSHED, *Chairman* ..... Westville
JOSEPH W. GARDAM ..... Newark
EDWARD C. KLEIN, JR. ..... Newark

Cancer Control

WILLIAM O. WUESTER, *Chairman* ..... Hillside
OTTO R. HOLTERS ..... Asbury Park
LEONID S. SNEGIREFF ..... Trenton
THOMAS B. LEE ..... Camden
JOSEPH I. ECHIKSON ..... Newark
W. JAMES MARQUIS ..... East Orange
H. WESLEY JACK ..... Camden
JOSEPH H. KLER ..... New Brunswick
PETER J. DEBELL ..... Passaic
JOHN L. OLPP ..... Englewood

Consultants

EMIL FRANKEL, Ph.D. (Institutions and Agencies) ... Trenton
RAYMOND V. BROKAW (Health) ..... Trenton

Cardio-Vascular Diseases

JEROME G. KAUFMAN, *Chairman* ..... Newark
HARVEY M. EWING ..... Montclair
CLARENCE L. ANDREWS ..... Atlantic City
PAUL A. KENNEDY ..... Englewood
THOMAS J. WHITE ..... Jersey City
LEROY W. BLACK ..... Rutherford
EVELYN HOLT ..... Summit
NICHOLAS A. ANTONIUS ..... Newark
FRANK J. ALTSCHUL ..... Long Branch
PATRICK H. CORRIGAN ..... Trenton
JULIAN COHEN ..... Paterson
NORMAN REITMAN ..... New Brunswick
HARVEY NUSSBAUM ..... Newark

Child Health

STANLEY NICHOLS, *Chairman* ..... Long Branch
HARROLD A. MURRAY ..... Newark
ERNEST G. HUMMEL ..... Camden
WALTER B. STEWART ..... Atlantic City
GEORGE M. LEVITAS ..... Westwood
L. CHARLES ROSENBERG ..... Newark
GEOFFREY W. ESTY ..... Westfield
CHESTER R. BROWN ..... Arlington
HAROLD F. TIDWELL ..... West New York
EDWARD P. DUFFY ..... Nutley

Consultants

THE NEW JERSEY FELLOWS OF THE AMERICAN ACADEMY OF PEDIATRICS

Conservation of Vision and Hearing

ELBERT S. SHERMAN, *Chairman* ..... Newark
HALVOR L. HARLEY ..... Atlantic City
REINOLD W. TERKUILE ..... Ridgewood
JAMES S. SHIPMAN ..... Camden
JOSEPH H. KLER ..... New Brunswick
JACOB J. MANN ..... Perth Amboy
CHARLES H. SCHLICHTER ..... Elizabeth
JAMES A. FISHER ..... Asbury Park
IRVIN LEVY ..... Trenton

Consultant

WILSON G. GUTHRIE (Education) ..... Trenton

Crippled Children

H. EUGENE READING, *Chairman* ..... Paterson
FREDERICK G. DILGER ..... Hackensack
LEOPOLD SZERLIP ..... Newark
TOUFICK NICOLA ..... Montclair
PAUL J. FINEGAN ..... Trenton
DAVID B. ALLMAN ..... Atlantic City
JOHN J. FLANAGAN ..... Newark
ELMER P. WEIGEL ..... Plainfield
HENRY H. KESSLER ..... Newark

Maternal Welfare

ROBERT A. MACKENZIE, *Chairman* ..... Asbury Park
ALFRED MEURLIN ..... East Orange
J. CARLISLE BROWN ..... Atlantic City
HOWARD C. CURTIS ..... Moorestown
SAMUEL A. COSGROVE ..... Jersey City
HERSCHEL S. MURPHY ..... Roselle
ALFRED D. SUMMERS ..... Princeton
GERALD W. HAYES ..... East Orange
RICHARD F. TOMEC ..... Montclair
JOHN D. PREECE ..... Trenton

Consultant

JULIUS LEVY (Maternal and Child Health) ..... Trenton

Mental Hygiene

HENRY A. COTTON, JR., *Chairman* ..... Trenton
THEODORE ROBIE ..... East Orange
GEORGE S. STEVENSON ..... Red Bank
LEWIS H. LOESER ..... Newark
LUMAN H. TENNEY ..... Princeton
CHARLES C. GRAVES, JR. ..... Marlboro
HENRY A. DAVIDSON ..... Flemington
ROLAND J. LYNCH ..... Secaucus
HARRISON F. ENGLISH ..... Trenton

Consultants

J. KENDALL WALLIS ..... Princeton
LEONARD SCHEINMAN (Veterans Administration) ..... Newark

Nutrition

S. WILLIAM KALB, *Chairman* ..... Newark
GEORGE M. KNOWLES ..... Hackensack
CLARENCE B. WHIMS ..... Ventnor
JAMES T. DODGE ..... Trenton
CHARLES F. CHURCH ..... New Brunswick
VINCENT P. DELDUCA ..... Camden
STEPHEN SEWELL ..... Spring Lake

Tropical Disease

CHRISTIAN P. SEGARD, *Chairman* ..... Leonia
FRANK J. ALTSCHUL ..... Long Branch
ARTURO R. CASILLI ..... Elizabeth

Consultants

EDWARD HENDERSON (Pathologist) ..... Bloomfield
REDGINAL HEWITT (Parasitologist) ..... Pearl River, N. Y.
LESLIE A. STAUBER (Zoologist) ..... New Brunswick

School Health

HAROLD F. TIDWELL, *Chairman* ..... West New York
VINCENT P. DELDUCA ..... Camden
ELI RUBENSTEIN ..... Bayonne
CHESTER R. BROWN ..... Arlington
WALTER E. D'ARCY ..... Trenton

Tuberculosis

ABRAHAM E. JAFFIN, *Chairman* ..... Jersey City
JOHN E. RUNNELLS ..... Scotch Plains
HAROLD S. HATCH ..... Morristown
RUFUS R. LITTLE ..... Oradell
MARCUS W. NEWCOMB ..... Browns Mills
CHARLES I. SILK ..... Perth Amboy
JOSEPH A. SMITH ..... Glen Gardner
MARTIN H. COLLIER ..... Camden
A. JOSEPH HUGHES ..... Camden
HOMER H. CHERRY ..... Paterson

Venereal Disease Control

ROBERT L. MCKIERNAN, *Chairman* ..... New Brunswick
WALTER E. LONGSHORE, JR. ..... Orange
IRWIN B. MARKOWITZ ..... Jersey City
MAURICE H. AXILROD ..... Atlantic City
DANIEL BERGSMA ..... Trenton
ISIDORE PINCUS ..... Newark
BAXTER A. LIVENGOOD ..... Woodbury
H. DONALD COWLBECK ..... Trenton
THOMAS M. MORRIS ..... Plainfield

ADVISORY COMMITTEES TO THE SUBCOMMITTEE ON MEDICAL PRACTICE

Meetings at the call of the Chairmen

Anesthesiology

HAROLD G. WALKER, *Chairman* ..... Wyckoff
ARCHER C. BUSH ..... Montclair
LEO J. FITZPATRICK ..... Englewood
NICHOLAS PALMA ..... Paterson
LESTER W. NETZ ..... Hackensack
EDWARD T. LAWLESS ..... Bloomfield

Contract Practice

ANDREW C. RUOFF, *Chairman* ..... Union City
GEORGE H. VAN EMBURGH ..... Arlington
MATTHEW F. URBANSKI ..... Perth Amboy
ARTHUR G. PRATT ..... Camden

Hospital Relationships

EARL H. SNAVELY, *Chairman* ..... Newark
GEORGE O'HANLON ..... Jersey City
J. HARRIS UNDERWOOD ..... Woodbury

Industrial Health and Hygiene

J. MALLORY CARLISLE, *Chairman* ..... Westfield
ARTHUR F. MANGELSDORFF ..... Plainfield
EDGAR E. EVANS ..... Penns Grove
AUGUSTUS GIBSON ..... Mendham

Medical Care of the Indigent

GEORGE BLACKBURNE, *Chairman* ..... Newark
J. WALLACE HURFF ..... Newark
BENJAMIN A. FURMAN ..... Newark
PAUL H. HOSP ..... Newark
HAROLD C. COX ..... Hightstown

Consultant

NORMAN M. SCOTT ..... Newark

Laboratory Medicine

ASHER YAGUDA, *Chairman* ..... Newark
A. HOBSON DAVIS ..... Paterson
SAMUEL A. GOLDBERG ..... Newark
FRANK W. KONZELMANN ..... Atlantic City
CARLOS A. PONS ..... Asbury Park

Nursing and Nursing Education

WALTER E. D'ARCY, *Chairman* ..... Trenton
A. CHARLES ZEHNDER ..... Newark
H. WESLEY JACK ..... Camden
HOMER I. SILVERS ..... Ventnor
WILLIAM T. READ, JR. ..... Camden

Pharmaceutical Problems

CHESTER I. ULMER, *Chairman* ..... Gibbstown
ALBERT B. KUMP ..... Bridgeton
JOHN L. VARRIANO ..... Jersey City
ANTHONY J. DIIELSI ..... Camden
LOUIS SCHNEIDER ..... Newark

Physical Medicine

BROR S. TROEDSSON, *Chairman* ..... Orange
MICHAEL J. O'CONNOR ..... Newark
JOSEPH F. A. RUBACKY ..... Passaic
ELMER J. ELIAS ..... Trenton

Radiology

W. JAMES MARQUIS, *Chairman* ..... East Orange
JOHN L. OLPP ..... Englewood
HARRY J. PERLBERG ..... Jersey City
PHILIP S. AVERY ..... Bound Brook
HARRY R. BRINDLE ..... Asbury Park
RAPHAEL POMERANZ ..... Newark

Workmen's Compensation

WILLIAM K. HARRYMAN, *Chairman* ..... Hackensack
ALBERT W. CLOUD ..... Englewood
H. BURTON WALKER ..... Vineland
MARCUS H. GREIFINGER ..... Newark
ROBERT H. HILL ..... Newark

Consultant

HENRY A. BRODKIN (Rehabilitation) ..... Newark

SPECIAL COMMITTEES

Military Service

REUBEN L. SHARP, *Chairman* ..... Camden
DAVID B. ALLMAN ..... Atlantic City
STEWART F. ALEXANDER ..... Park Ridge
STUART Z. HAWKES ..... Newark
WILLIAM G. HERRMAN ..... Asbury Park
ANDREW F. MCBRIDE, JR. ..... Paterson
WALTER F. PHELAN ..... Elizabeth

Study of Medical Care

NORMAN M. SCOTT, *Chairman* ..... Newark
FREDERIC J. QUIGLEY ..... Union City
HARROLD A. MURRAY ..... Newark
SAMUEL BLAUGRUND ..... Trenton
SAMUEL ALEXANDER ..... Park Ridge
C. BYRON BLAISDELL ..... Long Branch
VINCENT P. BUTLER ..... Jersey City

Veterans Liaison

JOSEPH F. LONDRIGAN, *Chairman* ..... Hoboken

DAVID B. ALLMAN ..... Atlantic City
SAMUEL J. LLOYD ..... Trenton
WILLIAM G. HERRMAN ..... Asbury Park
EARL LEROY WOOD ..... Newark

OFFICERS OF COUNTY MEDICAL SOCIETIES

County	President	Secretary	Reporter
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BERGEN	Albert W. Cloud, Englewood	Edward V. Sexton, Teaneck Tel. 6-7740	H. E. Reinbold, West Englewood
BURLINGTON	G. E. McDonnel, Mt. Holly	Howard C. Curtis, Moorestown Tel. 0646	T. Bruce Dickson, Riverton
CAMDEN	James S. Shipman, Camden	Arthur G. Pratt, Camden Tel. 0004	Harold K. Eynon, Camden
CAPE MAY	J. S. D. Eisenhower, Wildwood	Clarence W. Way, Sea Isle City Tel. 3-5521	Clarence W. Way, Sea Isle City
CUMBERLAND	Sidney L. Siegel, Millville	F. Muriel Ramsey, Millville Tel. 31	Edwin C. Greene, Bridgeton
ESSEX	Harrold A. Murray, Newark	Marcus H. Greifinger, Newark Tel. Market 3-1918	Asher Yaguda, Newark
GLOUCESTER	Joseph F. Hughes, Woodbury	Clarence A. Bowersox, Woodbury Tel. 100	Louis K. Collins, Glassboro
HUDSON	Claudio E. McNenney, Jersey City	Vincent P. Butler, Jersey City Tel. Delaware 3-7855	Harry J. Perlberg, Jersey City
HUNTERDON	Raymond J. Germain, High Bridge	Philip W. Baker, High Bridge Tel. 170-R-2	Philip W. Baker, High Bridge
MERCER	C. Chester Chianese, Trenton	A. Dunbar Hutchinson, Trenton Tel. 3-5542	A. Dunbar Hutchinson, Trenton
MIDDLESEX	Frederick S. Taber, New Brunswick	Oscar J. Sokoloff, New Brunswick Tel. 2-5366	W. R. Greenwood, N. Brunsw'k
MONMOUTH	Louis F. Albrigbt, Spring Lake	Elsworth F. Baker, Marlboro Tel. Freehold 1166	Helen E. Jones, Asbury Park
MORRIS	Alden P. King, Dover	Stanley Teskey, Bernardsville Tel. 213	John S. Forbes, Jr., Basking Rdg.
OCEAN	Norman F. Szold, Lakewood	Harvey Rinzler, Toms River Tel. 8-0408	B. W. Gartlan, Toms River
PASSAIC	Harry Wolfson, Paterson	Irving Okin, Paterson Tel. Lambert 3-6686	Joseph E. Mott, Paterson
SALEM	William T. Hilliard, Salem	Harry F. Suter, Penns Grove Tel. 65	William H. Miller, Woodstown
SOMERSET	James L. Young, Somerville	Arthur F. Mangelsdorff, Bound Br'k. Tel. 500	William F. Jones, Somerville
SUSSEX	Martin I. Kirschner, Vernon	James H. Spencer, Jr., Newton Tel. 605	Katherine E. Stewart, Ogdensburg
UNION	Stanton H. Davis, Plainfield	Edward G. Bourns, Westfield Tel. 2-2285-J	E. M. Satulsky, Elizabeth
WARREN	Walter A. Boquist, Phillipsburg	William H. Varney, Washington Tel. 777	J. C. Humbert, Jr., Stewartsville

WOMAN'S AUXILIARY

President, MRS. LODOVICO MANCUSI-UNGARO, Newark

President-Elect, MRS. ROBERT B. WALKER ..... Highland Park
First Vice-President, MRS. C. CHESTER CHIANESE ..... Trenton
Second Vice-President, MRS. THOMAS P. McCONAGHY ..... Camden
Recording Secretary, MRS. BANKS S. BAKER ..... Camden
Corresponding Secretary, MRS. PHILIP J. SANTORA ..... Newark
Treasurer, MRS. GERALD E. McDONNEL ..... Mt. Holly

Directors

MRS. JOSEPH E. MOTT ..... Paterson
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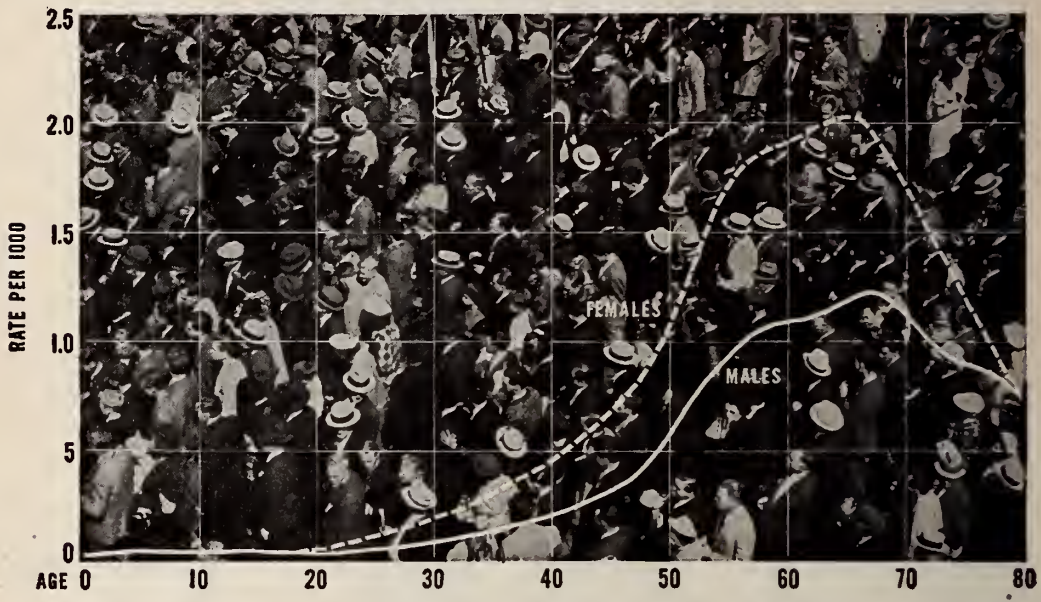
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1. Spiegelman, M., and Marks, H. H.: Am. J. Pub. Health 36:26 (Jan.) 1946. 2. Statistical Bull., Met. Life Ins. Co. 27:6 (Feb.) 1946.

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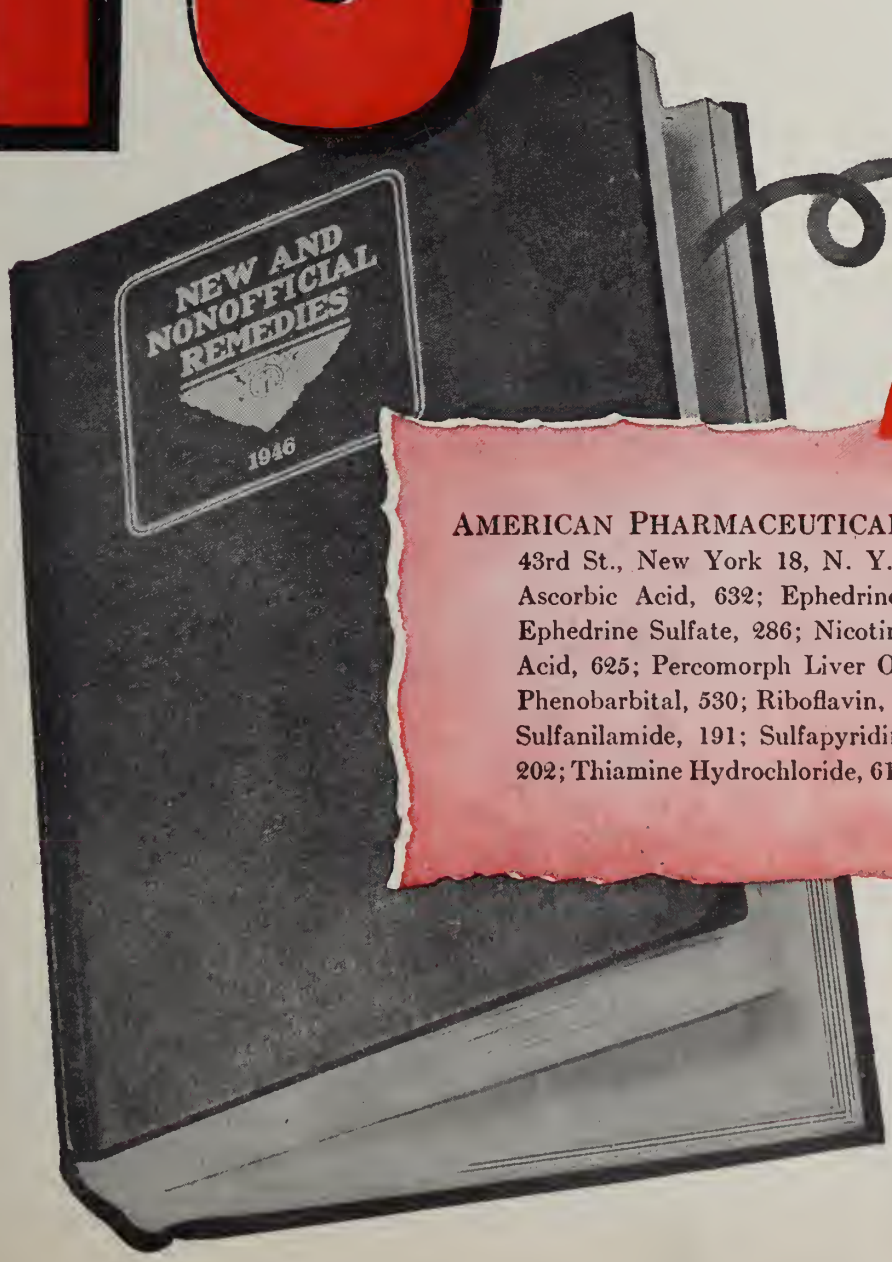
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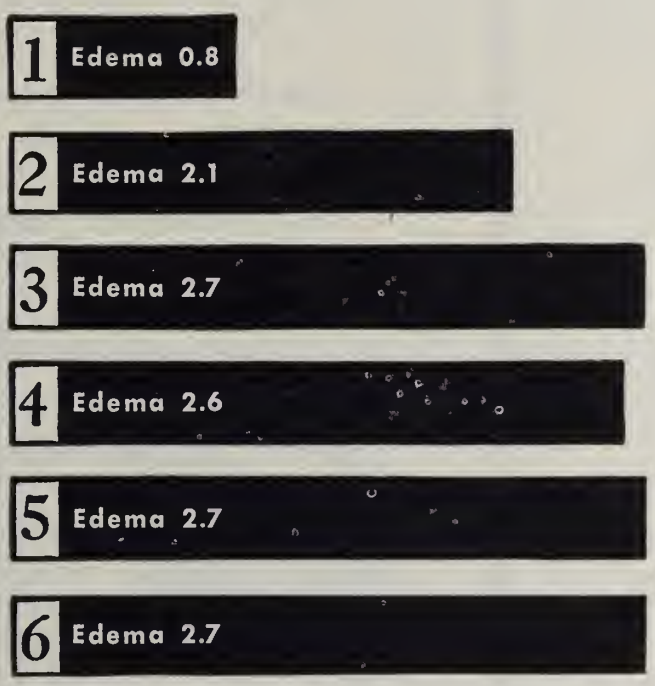
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1. Surg., Gynec. and Obst 74:390 (Feb. 16) 1942.

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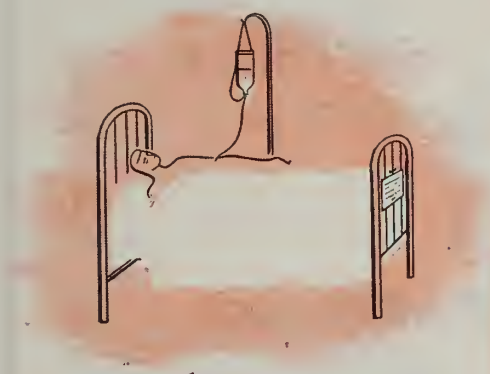
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Editorial: Surg., Gynec. & Obst. 83:259, 1946



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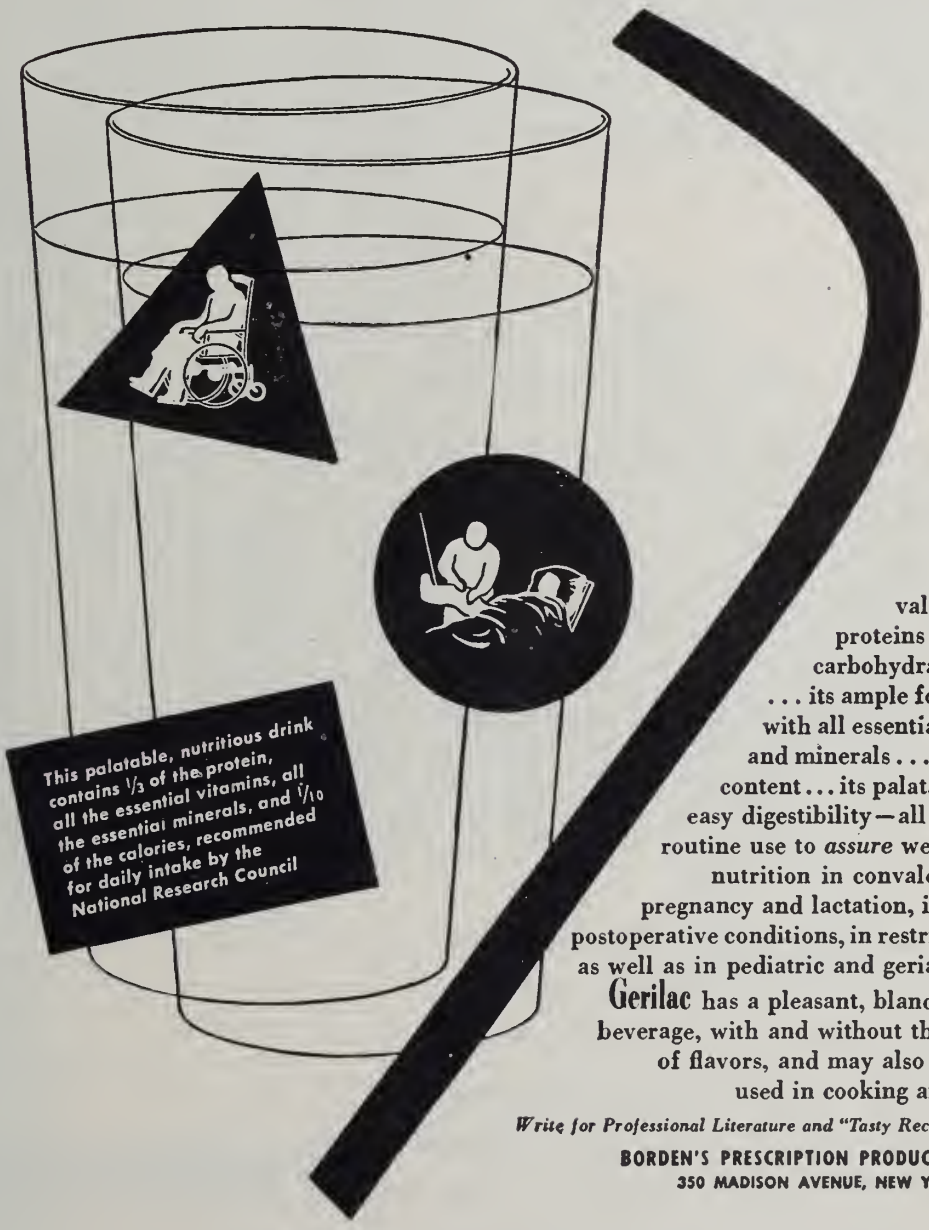
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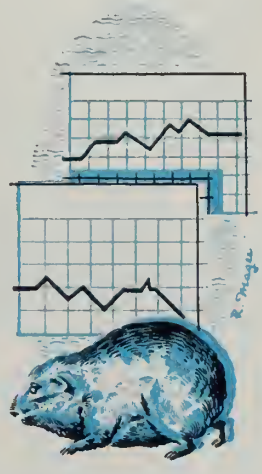
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Henry C. Barkhorn, M.D.,
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Henry A. Davidson, M.D., Editor

Miriam N. Armstrong,
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THE PRESIDENT'S PAGE

THE CANCER CONTROL PROGRAM

The control of cancer continues to be the gravest and most important medical problem concerning the profession today. In the past few years, the American Cancer Society in general and the New Jersey Chapter in particular, have made tremendous progress in securing adequate funds with which to carry out an intensive educational campaign among the laity, to develop greater cancer consciousness on the part of the members of the medical profession, to establish research projects, to provide adequate diagnostic and therapeutic facilities throughout New Jersey and perhaps ultimately to deal with the tragic social and economic aspects of the care of the terminal cancer patient.

The New Jersey Chapter of the American Cancer Society, under the able leadership of Mr. George E. Stringfellow, is attacking the problem with vision, vigor and enthusiasm. But it cannot be solved by the American Cancer Society alone. They will provide the funds and will distribute them intelligently with the view to securing a dollar's value for a dollar expended. The medical and nursing professions must supply the skilled personnel to conduct the actual diagnosis and treatment of cancer cases. In the words of Mr. Stringfellow "neither group can succeed alone; together they will not fail".

It is axiomatic to say that all hope of improvement in our management and control of cancer depends on early diagnosis. To this end an intensive educational campaign must be conducted among the laity to acquaint them with the signs and symptoms which may be indicative of cancer in its early stages, and to urge and encourage them to seek competent medical advice promptly upon the appearance of suspicious signs or symptoms; at the same time the program should be counter-pointed by the hopeful outlook in cancer provided treat-

ment is undertaken early. A similar campaign must be conducted concurrently among physicians, not to educate them in regard to the symptoms and signs of cancer but rather to make them cancer conscious and stimulate them to investigate thoroughly all suspicious lesions. We must train ourselves not to minimize a patient's suspicions or fear of cancer until thorough and complete investigation has made its presence at least improbable. The physician who airily dismisses a worried patient with a reassuring word and a pat on the shoulder, may be doing him a grave disservice.

The Advisory Committee on Cancer Control of The Medical Society of New Jersey, under the dynamic direction of Dr. Wuester, has made excellent progress in formulating plans for various types of cancer diagnostic and treatment clinics. The complete program has been published in recent issues of our JOURNAL.* This part of the work has been so well done that the United States Public Health Service has formally recognized it, and has requested permission to adopt it for general distribution throughout the United States. In addition, the Advisory Committee has established a state wide biopsy service which is an absolutely essential part of the cancer program; and it has assembled a group of expert pathologists who will examine and report upon all sections sent to them for diagnosis. The development of the central tumor registry is another great advance.

Although our Advisory Committee is doing such excellent work, it cannot carry out an effective program without the aid of every practicing physician. It is the private practitioner to whom the vast majority of early cases of cancer first apply for diagnosis, advice and treatment. The private practitioner is therefore the keystone of the whole program. Without his interest and determined cooperation we can not expect maximum results. The most competent surgical, x-ray and radium treatment will avail the sufferer from cancer relatively little if the disease is even moderately advanced.

Wholehearted cooperation of the entire membership of The Medical Society of New Jersey with the New Jersey Chapter of the American Cancer Society will represent an outstanding example of an attempt to solve a pressing problem of great magnitude by private enterprise. Success in the program will be a magnificent contribution to the public welfare and will add lustre to the bright shield of American medicine.

ROYAL A. SCHAAF, M.D.,
President,
The Medical Society of New Jersey.

* September 1946, February 1947, and May 1947.

WHAT IS A HOSPITAL?

So long as a hospital remains a practitioner's work shop, the institution is an adjunct to the practice of medicine. Its professional policies are determined by physicians. The visiting doctor practices medicine; the hospital furnishes food and lodging. Whatever medical service the hospital does offer (such as taking x-rays, administering anesthesia, examining tissues) is rendered with the consent of, and according to principles adopted by, the medical staff.

As a hospital grows, however, it sometimes crosses a poorly defined and poorly guarded frontier. This is the point where the practice of medicine *in* a hospital crosses the practice of medicine *by* the hospital. Beyond this stage, the hospital becomes not an adjunct, but a competitor to the practitioner. Thus, if it is

logical for the hospital-salaried radiologist to take an x-ray picture, it seems equally logical for him to administer an x-ray treatment. If the procedure can be done efficiently for in-patients, why not for out-patients? And if it is logical for the pathologist to study a biopsy removed in the hospital's operating room, why not let him study tissue removed in the doctor's office?

As far back as 1937, the American Hospital Association said editorially* "Care of the ambulatory sick becomes increasingly the function of the hospital . . . The patient whatever his economic status is entitled to the necessary services of the clinician, the surgeon, the pathologist, the radiologist . . . all these services are part of the hospital".

If all these services (note that the surgeon and clinician are included) are part of the hospital, what is left for the private practitioner? The hospital's intrusion into medical practice seems to move by three stages. First, the institution offers only the lodging and feeding of the patient. Then it provides equipment which the doctor functioning as an independent private practitioner, can use on patients housed in the hospital. Then it retains doctors, nurses and technicians to use this equipment. When this final stage is complete, the doctor will be an employee who can be hired, and—let it be remembered—fired by the administrator or board of the hospital.

Perhaps this transformation of the hospital is a sign of progress. There are those who do not think so. Dr. Herrman's article on the subject, elsewhere in this issue, presents the case for the negative. Certainly the medical brotherhood may, if it wishes, convert itself from a profession into a guild of employees. But if the doctors make such a change, they should do so with their eyes wide open.

* Editorials in the May 1937 and September 1937 issue of *Hospitals*.

AN OPEN LETTER TO THE NEW JERSEY PRACTITIONER

May 12, 1947.

Dear Doctor:—

Not long ago you, as a member of organized medicine, were drafting every person you could reach to fight the threat of socialized medicine, only to overlook a large potential force in your own home.

Have you ever considered the influence your wife might have working as an individual in other organizations? We of the Auxiliary are seriously trying to follow and to understand some of the many problems you face outside the practice of medicine, and to protect your interests where we can. If your wife is not a member of the Auxiliary and if you have not devoted the time to helping her understand things of interest to organized medicine, you are depriving her of the chance of assuming leadership among the local women's groups in health education. And you are missing a chance to recruit a spokesman in outside organizations.

New Jersey has eight county medical societies with no Auxiliaries. Thus in eight counties, policy-forming movements among women's groups do not in any way feel the guidance of The Medical Society. This can be changed only by the interest each of you take in seeing that these counties become active.

As president of the Auxiliary to your Medical Society I am anxious to serve you to the best of my ability, and would therefore deeply appreciate any help or suggestions any of you could give toward solving this problem.

Sincerely,

FRANCES MANCUSI-UNGARO,
President, Woman's Auxiliary
The Medical Society of New Jersey.

ORIGINAL ARTICLES

SOME RECENT ADVANCES IN CHEST SURGERY

RICHARD H. DIEFFENBACH, M.D., Newark, N. J.

In the past few years so much has been added to our knowledge of the surgical treatment of cardiovascular lesions of the congenital type, and in the treatment of hemothorax, that a review of these advances might be of value. It is difficult for the general practitioner to plow through the voluminous literature on these newer measures and to evaluate all the contributions. Yet the family physician is the main cog in the patient-practitioner-specialist relationship, and the one upon whom the patient depends for advice. It therefore seems appropriate to review what has been accomplished in this field and acquaint the general practitioner with these advances.

Congenital cardiovascular lesions have been divided by Abbott[1] into two classes, the acyanotic and the cyanotic groups. In the acyanotic group, those amenable to surgical correction are patent ductus arteriosus and coarctation of the aorta. In the cyanotic group, certain cases of the tetralogy of Fallot may be relieved.

COARCTATION OF THE AORTA

In the adult type there is a very localized constriction of the aorta, usually just distal to the ductus arteriosus. The latter is not, as a rule, patent. In the so-called infantile type of coarctation, the constriction is more extensive, involving that part of the aorta between the left subclavian and the ductus arteriosus. This condition is incompatible with long life and most of the infants die in a few hours. The oldest lived nine months.

In the adult type the coarctation is very localized, either at, or just distal to, the ductus arteriosus. This leaves the innominate, left common carotid, and left subclavian arising from the aorta proximal to the constriction, so that the circulation to the upper extremities and head is not embarrassed. All grades of narrowing may occur. Some are so slight that they are hardly discernible in autopsies; others show complete closure. The condition is more common in the male.

The results of marked coarctation of the adult type are of interest. Proximal to the constriction, the aorta may be markedly dilated —in fact, aneurysmal—and the rupture of the latter is one of the causes of death. Distally, the aorta is usually narrow. Nature attempts to form a collateral circulation. This takes place through the internal mammary, scapular, and intercostal vessels. A hypertension usually develops, probably due to interference with the renal blood supply (hypertensine and angiotene). If the collateral circulation is adequate, there may be no hypertension.

Bearing in mind the pathology, one readily can visualize the signs and symptoms in a pronounced case of coarctation, always remembering that there may be none if the constriction is slight or minimum. In high grade constriction, there may be a long systolic murmur, heard over the precordium and back. There also is a marked discrepancy between the blood pressure of the upper and lower extremities. The former may be 200 millimeters and the latter 100 or less. Evidence of collateral circulation between the upper and lower halves of the torso may be seen along the course of the internal mammary, intercostal, scapular, and deep epigastric arteries. On x-ray, there is an absence, or decrease in the size, of the aortic knob, often a dilatation of the ascending aorta and first part of the arch. There is, however, no descending aorta visible in the lateral or oblique views. Notching of the ribs, due to pressure of dilated intercostals, may be demonstrated by x-ray. There also usually is an enlargement of the heart, especially to the left, with a variable amount of cardiac failure.

Treatment. White[2] states that: "There is

1. Abbott, Maude E.: Congenital Heart Disease in Nelson's *Medicine*, page 207 of volume 4. (Thomas Nelson & Son, New York, 1927.)
2. White, Paul D.: *Heart Disease*, page 307, 3d edition. (Macmillan, New York, 1944.)

no specific treatment for congenital coarctation of the aorta, but the subject should be protected as much as possible from strain and infection." Since this was written, Crafoord[3] of Sweden has operated upon seven cases, with one death, and good results in those who survived. Gross of Boston, Blalock of Baltimore, and others, have likewise had successful results with surgery. It is not the purpose of this paper to describe the surgical technic, except briefly to state that the constricted area is excised and an end to end angiorrhaphy performed.

DUCTUS ARTERIOSUS

The ductus arteriosus, also known as ductus Botalli, in the fetus shunts most of the blood from the pulmonary artery into the aorta, and should gradually close after birth so that, within a few weeks, nothing remains but a fibrous cord. If it persists after three months, it is regarded as a congenital anomaly. It is one of the more common defects, but is frequently overlooked by physicians. It may exist alone, or in combination with other defects. It occurs more commonly in the female. The patency may vary greatly; sometimes the duct admits only a fine probe. It may be very short, so that there is practically a direct communication between the aorta and pulmonary artery, or it may be as long as two centimeters.

Signs and Symptoms. There usually are no subjective symptoms, though the patient may occasionally be conscious of a harsh murmur or thrill. On examination, there is a continuous loud murmur accentuated in systole and maximal over the pulmonary artery just at the left of the sternum at the second costo-cartilage and interspace, and generally accompanied by a thrill. It may be transmitted to the neck, and has been described as a machinery-like whirr or hum.

X-ray shows unusual prominence of the heart shadow in the region of the pulmonary arteries and, under fluoroscope, these can be seen to pulsate. There is no cyanosis with this condition, and the patient rarely is aware of its presence. Its menace lies in the fact that at least 25 per cent of these patients will develop subacute bacterial endocarditis or endarteritis. For this reason, serious thought should be given the correction of this condition.

Treatment. The first successful procedure was reported by Gross.[4] The ductus has been ligated without being excised or severed. Some of these have recurred. The latest treatment is double ligation with excision, or complete removal with suture of the defects in the aorta and pulmonary artery.

TETRALOGY OF FALLOT

There remains to be discussed another congenital defect amenable to surgical relief, and that is pulmonary stenosis or pulmonary atresia. This condition rarely exists alone and usually is associated with other anomalies, most commonly with the tetralogy of Fallot. This is accompanied by marked cyanosis and is called by the French *maladie bleue.* The latter consists of an intraventricular defect (basal septal), pulmonary stenosis, dextro-position of the aorta, and hypertrophy of the right ventricle. The aorta frequently is placed directly over the point where the intraventricular septum should be located, and has been designated by Spitzer as a *reitende* aorta. The arch of the aorta usually turns and then descends to the right of the vertebral column.

Symptoms and Signs. These are: deep cyanosis, clubbing of the fingers and toes, polycythemia, elevated hemoglobin, sometimes hemoptysis, and marked dyspnea. The clubbing is not present at birth, but develops later. Children who are old enough to walk may be able to take only a few steps before they become exhausted. There may be no murmur, especially if the septal defect is large. If present, the murmur is usually systolic in time, and loudest just to the left of the sternum, where there also may be a thrill. Electro-cardiogram shows right preponderance, high P wave in leads I and II, and occasionally ventricular extra systole. There usually is no cardiac enlargement, either on physical examination or x-ray (Taussig). Roesler describes a boot-shaped heart, *coeur en sabot;* but this is unusual and probably occurs only in late cases.

3. Crafoord and Nylin: Journal of Thoracic Surgery, 14: 307 (1945).
4. Gross, R. E., and Hubbard, J. P.: Journ. Amer. Med. Assn., 112:729 (1939).

When the esophagus is visualized by contrast material, the pressure from a right-sided aortic heart may be demonstrated. Viscosity of the blood is markedly increased. The oxygen capacity may be doubled, whereas the oxygen saturation is halved. From those facts one realizes that it may be difficult to make an exact diagnosis, but every effort should be made to come to a definite conclusion because, in certain cases, the sufferer may be helped.

Treatment. A great deal of credit must be given to Dr. Helen Taussig of Johns Hopkins, who first suggested a solution for this problem. Her reasoning was based on the fact that, in certain cases of pulmonary arterial hypoplasia as seen in the tetralogy of Fallot, a collateral circulation was established. This occurred sometimes through the bronchial arteries, in other cases through enlarged esophageal vessels, and in one case an artery was found arising from one of the branches of the arch of the aorta. It anastomosed with one of the pulmonary arteries. This suggested that an anastomosis between a systemic and a pulmonary artery could be established surgically. The proposal was acted upon by Blalock[6] who, after animal experimentation, carried out the operation on a child. At present, it has been found most advantageous to make a side to end anastomosis between the subclavian and one of the pulmonary arteries, selecting the subclavian arising from the innominate. One, therefore, first must ascertain in which direction, right or left, the arch of the aorta is located. There are many other details, and tests which must be made, so that only those patients are subjected to operation who have a chance of being relieved by surgery.

This, of course, is not a cure but does relieve the sufferer greatly. Time will tell how long these cases will survive and what the ultimate outcome will be.

In a thousand cases of congenital cardiovascular defects analyzed by Abbott,[7] there is no classification of tetralogy of Fallot as such. The cases are divided into "marked cyanosis" and "extreme cyanosis". Some of these are typical of the tetralogy; others lack one or more requirements. However, they may be considered as cases which could be benefitted by surgery. Including both types, there were 83 cases of marked cyanosis and 31 of extreme cyanosis. This makes an incidence of 11.4 per cent in her series. The most serious complication which threatens these patients is acute, or subacute, bacterial endocarditis or endarteritis.

5. Gross, R. E.: Surgery, Gynecology & Obstetrics, 78:36 (1944).

6. Blalock, A., and Taussig, H. B.: Journ. Amer. Med. Assn., 128:189 (1944).

7. Abbott, Maude E.: Congenital Cardiac Disease in Osler's *Modern Medicine*, volume 4. (Lea & Febiger, Philadelphia, 3d edition, 1927.)

CLOTTED HEMOTHORAX

What is the present status of hemothorax? There always has been considerable controversy about whether blood in the pleural cavity does or does not clot. The pleural cavity does seem to have an inhibitory influence on coagulation. We all have aspirated chest fluid and observed, in certain cases, that after removal the fluid clots. On the other hand, blood does coagulate in the pleural cavity and, if infected, creates an additional problem.

After experience in the recent war, the position taken by most chest surgeons is as follows: one must first ascertain if the blood is coming from a pulmonary lesion or from a chest wall vessel such as an intercostal artery. If the hemorrhage is of pulmonary origin, early aspiration of blood is advised, without air replacement. If there are no signs of respiratory embarrassment, the aspiration may be deferred for 48 to 72 hours. Air replacement is not advised because if infection exists or supervenes, a complete empyema involving the apical region will result. Fever is frequently present, even in uninfected cases. Most hemothoraces can be satisfactorily aspirated and the lung reexpanded. A large needle, No. 15 gage, should be used, and if this fails, catheter drainage may be instituted, though the latter is usually unsuccessful.

If these measures prove ineffective, and an organized clot forms, the surgeon should consider surgical intervention, especially if the organized clot fixes the lung so that there is retraction of the intercostal spaces and no lung expansion. The lung compression should amount to at least 50 per cent, and decortication is particularly indicated when the apex is

collapsed, when aspiration has been unsuccessful, when there has been no pulmonary re-expansion for from three to five weeks, or when there are multiple cystic collections which do not communicate freely. There are certain borderline cases in which carefully considered judgment will be needed to decide whether or not to operate.

This decordication is best performed three to five weeks following the injury. Not only must all the clots be removed, but the fibrous tissue over the visceral pleura, between the lobes and on the diaphragm, must be peeled off, so that the lung expands fully when intertracheal pressure is applied by the anaesthetist. This layer of organized tissue, which may be a full centimeter thick, is found not only on the visceral pleura but also on the parietal. The latter does not need to be removed, because it seems to help re-expansion but little. If this clot and organized tissue are not removed, the lung eventually will be invaded by fibroblasts and be contracted into a hard, non-expandable mass of fibrous tissue, causing both a limited lung capacity and a marked chest deformity.

Nothing has been mentioned about surgery of pulmonary tuberculosis, carcinoma of the lung or esophagus, or mediastinal tumors, because that would defeat the purpose of this article, which is to present a brief review which the general practitioner can read in a short time.

570 Mt. Prospect Avenue

ROLE OF X-RAY IN RINGWORM OF THE SCALP

The ringworm of the scalp epidemic, prevalent in many cities in the United States, affects approximately four boys to every girl, according to Lee Carrick, M.D., who made a study of 171 cases.

Writing in *The Journal of the American Medical Association,* Dr. Carrick states that x-ray removal of the diseased hair by the roots is the treatment of choice but "there are neither the facilities nor enough qualified personnel available for successful execution of such a tremendous task."

Three ointments, one developed from a copper compound and the other two from some fatty acids and their salts, are described by the author as valuable for local treatment in the fight against ringworm of the scalp. However, the author cautions that none of these ointments shoud be considered a substitute for x-ray removal of the hair.

Between October, 1944, and March, 1946, 171 children were examined. One hundred and sixty-nine of this number (98.8 per cent) had fungi of the human type and two had fungi of the animal type. Of the 171 cases only 32 (18.7 per cent) were in girls as compared to 139 in boys (81.3 per cent), the ratio of boys to girls being 4:1.

Examination under the Woodlight revealed ringworm of the scalp in these patients. In a darkened room, under this light, normal skin and hair fluoresce faintly, while hairs infected with the fungi show brilliant beads of fluorescence and scaly areas appear turquoise blue. Parents should suspect the presence of the disease with the discovery of round bald spots on the scalp, ranging from the size of a 10 cent piece to that of a silver dollar, or even larger.

Since nursing care plays an important role in the treatment of this infection, Dr. Carrick suggests that printed directions for home care be given to mothers of young patients.

OUTLOOK FOR CHILDREN WITH DIABETES

"What chance has a seven year old child of recovering from diabetes?" a reader asks in *Hygeia,* health magazine of the American Medical Association.

"Complete cure of diabetes is not possible," states *Hygeia.* "However, as a result of medical advances it is possible to assure the average diabetic child of as long a life as any other person. In fact, at least one insurance company is now accepting policy applications from diabetics. It must be realized though that rather strict supervision is necessary in all patients with diabetes and frequent medical consultation is advisable."

HOSPITAL PRACTICE OF MEDICINE *

William G. Herrman, M.D., Asbury Park, N. J.

When I was a boy in a small New York State town there were offices over the stores on Main Street with signs that read: John Jones, Electrical Engineer; Sam Smith, Civil Engineer; Benjamin Brown, Mechanical Engineer; as well as George Green, Lawyer; William White, D.D.S., and Bernard Black, M.D. There are a few independent members of the first three engineering professions today but big business has gobbled up most of them and they are technical employees receiving, in many cases, less monetary return than unskilled laborers who are highly unionized.

Many attorneys, physicians and dentists are also employees; but, as yet, the majority are more or less independent practitioners. Most states have laws prohibiting the practice of medicine and other learned professions by corporations; so it has been difficult for big business to capture these three professions except through the formation of eleemosynary corporations which no one wishes to sue.

Protection of the public falls within the police power of the state whether that protection be against the foe without or within. Most of us can find little fault therefore with the operation, by local or state government, of hospitals for the care of contagious or mental diseases. Most such hospitals have been established by and are being run by the government. But most hospitals in this country for the care of other diseases were founded by busy physicians, and public spirited citizens, as doctors' workshops where some sick could be cared for better than at home or in the doctor's office. Most of them from their inception took care of the ill regardless of economic status and so were on a "charity" and "no-profit" basis from the beginning. There was no thought at first that these institutions would practice medicine. They merely furnished a place where *doctors* could practice medicine. Physicians gave their time freely to the care of those who could not pay, confident that, in return, these institutions (not run for profit) would protect them in the private practice of medicine by excluding from ward or clinic care those able to pay for medical attention. As these institutions grew and became more complicated in equipment and procedures, the busy doctors withdrew more and more from the administrative side so as to give their time and skill to the actual care of the ill, feeling that their own interests, as well as those of the patients were best left in the administrative care of public spirited laymen, friends of both. Such is the background of the two institutions in Monmouth County, for instance.

But today what do we see? Some hospitals sell, for a flat fee, a complete diagnostic service, regardless of economic status; or a complete obstetrical set-up; or "packaged" tonsillectomies or other surgical operations. Some hospitals hire salaried physicians and patients pay the hospital for all services rendered. Others pay their physicians and surgeons according to an agreed schedule while they charge the patient a price they themselves arrange. Such institutions may not be in the majority; yet their number is growing. Many more sell the services of radiologists, pathologists and anesthesiologists regardless of state laws. This the general profession has long tolerated forgetting that what today may be another's problem may tomorrow be their's. Now they see it but the hour is late.

The House of Delegates of the American Medical Association has on many occasions declared against the selling of medical services by hospitals and the code of ethics of the A. M. A. declares: "It is unprofessional for a physician to dispose of professional attainments, or services to any lay body, organization or group of individuals, by whatever name called, or however organized, under terms or conditions which permit a direct profit (from the fees, salary, or compensation received) to accrue to the lay body or individual employing him". Yet, this practice is increasing and the American Hospital Association has flatly

* Read at the meeting of the New Jersey members of the American College of Physicians, Newark, N. J., November 9, 1946.

stated *"Diagnosis, treatment and care of the ambulatory sick become increasingly the functions of the hospital* as the hospital develops into the center of community health activities"; and again "the patient, whatever his economic status, is entitled to receive the service of the clinician, the surgeon, the pathologist, the radiologist, the nurse and the lay people who attend him. All these services are part of the hospital". The majority report of the Committee on the Costs of Medical Care rendered in 1932 recommended just this objective. This might be called the opening gun in the campaign, while the Wagner-Murray-Dingell bill was the barrage to finish the battle. Let us hope that the heavy rainfall last November will put a quietus on such efforts.

Now how has this all come about, and just who is to blame and what is to be done? Most of it has taken place during the last seventeen years. Beginning with 1929, endowments and contributions from the wealthy have been more and more curtailed. By 1929 we had 7000 hospitals in this country with a capital investment of over three billion dollars with a 22 million dollar a year expansion. This is "Big Business" and it had to look around for new sources of income. For this reason were sponsored group hospitalization, out-patient clinics for pay and the "middle man" attitude of hospitals in the sale of medical services with which we are all so familiar.

Who is to blame? First, the physician himself. Twenty-five years ago most community hospitals were "doctors' hospitals". Physicians were on the boards of trustees and executive committees of hospitals and hospital policies were largely controlled by doctors. Look around you today how many of you are on such boards and committees? Second, that new kind of specialist the hospital administrator. Not a nurse or a doctor but a business man—a career man. Bigger and better hospitals, "centers of community health" make his job all the more important and his salary the larger. In my medical school days most hospital superintendents (that was the name then) were nurses or doctors. Medical service and assistance to that service was the desideratum, not income or "front". Don't blame the business man serving as a trustee; he but uses his training and his experience in the only way he knows to further what he calls a "worthy cause". He has to be advised and guided by the professional man and not left entirely to the hospital administrator, who has been playing a studied and successful game for the last twenty years to cast the doctor out of the hospital council.

The interests of the patient, for whom after all the hospital was built, are our interests and our interests are his. An independent, unfettered, competent medical profession means better health for him. We must get back in the saddle for his sake and ours. Hospital streamlined mass production medical care of cases, not patients, is more a menace today than socialized medicine of which it is the corollary and forerunner. Physicians wake up!

501 Grand Avenue

LASKER AWARD TO JERSEYITE

One of the coveted Lasker Awards,—the American Public Health Association's top honor for medical research—goes to Dr. Philip Levine, New Jersey resident and member of The Medical Society of New Jersey. Dr. Levine shares the award with his co-worker, Dr. Alexander Wiener, and their spiritual godfather, the late Dr. Karl Landsteiner. The full citation reads:

"Equipped with the precise tools of modern immunology, and applying these tools with the utmost astuteness, Doctors Landsteiner, Levine and Wiener discovered the existence in normal human blood of previously unknown hereditary factors which, if not taken properly into account, are capable of causing serious illness or death to unborn and newborn children, and to persons who receive blood transfusions.

The meticulous and successful researches of these scientists have already saved the lives of innumerable human beings—adults and children—and will save the lives of millions yet unborn."—Presented at Cleveland, Nov. 12, 1946.

PEPTIC ULCER TREATED WITH PROTEIN HYDROLYSATE*

REPORT OF THREE CASES

Edward Margaretten, M.D., and Lawrence A. Kamer, M.D.,
Perth Amboy, N. J.

Since proteins have acid-binding properties, it seems reasonable to use them for the treatment of peptic ulcer. Indeed, in 1939 Windwer and Matzner [1] did propose a high protein diet for the treatment of peptic ulcer. In their regime, they added 56 grams (1¾ ounces) of gelatine daily to the ambulatory treatment advocated by Alvarez.[2] More recent reports of Co Tui, Lund,[3] Levenson and Ellman [4] indicate that a diet high in proteins, calories and vitamins may be of therapeutic value in treating peptic ulcer.

There seems to be definite advantages in effecting this high protein intake by the use of amino acids. Amino acids are indicated whenever there is failure in normal ingestion, digestion and absorption [4] of protein in food. Such deficiencies are noted in severe gastrointestinal disease or persistent vomiting or diarrhea from any cause. In such cases, amino acids must be given parenterally. This includes:

1. Intestinal obstruction.
2. Local or generalized peritonitis.
3. Acute cholecystitis.
4. Severe peptic ulcers in which the ingestion of any food provokes severe pain or vomiting.
5. Gastro-intestinal carcinoma where amino acids are used to build the patient up to be able to undergo an operation.
6. Post-operative cases in which abdominal operations have been performed if nothing by mouth is permitted in order to achieve gastrointestinal rest. The use of proteins to enable more rapid healing is highly recommended in the literature.[3]
7. Pernicious vomiting of pregnancy.
8. Vomiting in pyloric stenosis.

Oral use of amino acid is effective when the difficulty encountered is in digestion and absorption.[4]

Amino acid is indicated in the quiet stage of gastroenteritis, ulcerative colitis, and regional ileitis.

In the acute stage in these conditions, parenteral administration of amino acids is advocated. Oral feeding of amino acids is also indicated in protein allergies. Here the amino acid provides the necessary nourishment without the presence of specific antigenic property of the protein molecule.

Oral feeding of amino acids is recommended for use in chronic and bleeding ulcers, as noted by Co Tui and by Levy and Siler.[12] This permits protein nourishment without the need for digestion and enables the amino acids to act as a buffer and thus neutralize gastric acidity.

PROTEIN HYDROLYSATE

Protein hydrolysate consists of casein which has been digested. Casein contains nine essential amino acids.[4] They are: lysine, tryptophan, valine, leucine, isoleucine, theosine, phenylalanine, arginine and methionine. Furthermore, casein contains these amino acids in very high proportion—about 54 grams per cent. The casein is converted into its amino acids which are readily absorbable and immediately useful to the body.

PROTEIN PHYSIOLOGY

Proteins are essential to human metabolism. They are digested in the stomach and small intestine and are absorbed in the form of amino acids. Parts of the molecule are used for replacing and building tissue and plasma protein. The remainder are deaminated chiefly by the liver with the formation of carbohydrate and non-protein nitrogenous products [5] which are excreted in the urine.

Proteins are obtained in the food and may be manufactured by the liver (e. g., fibrinogen and albumin). The healthy individual requires one gram of protein per kilogram of body weight.[6] Twice as much, and even more, is recommended in certain disease states.

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* From the Medical Service, Perth Amboy General Hospital.

1. Windwer, C., and Matzner, M. J.: Amer. Jour. Dig. Dis., 5:743 (1939).
2. Beckman, H.: Treatment in General Practice. W. B. Saunders Co., 4th Ed., 1942, p. 517.
3. Lund, C. C., and Levenson, S. M.: J. Am. Med. Assn., 128:95 (1945).
4. Ellman, R.: J. Am. Med. Assn., 128:659 (1945).
12. Levy, J. S., and Siler, K. A.: Am. J. Digest. Dis., 9:354, 1942.
5. Stare, F. J., and Davidson, C. S.: J. Am. Med. Assn., 127:985 (1945).
6. Sherman, H. C.; Gillet, L. H., and Osterberg, E.: J. Biol. Chem., 41:97 (Jan.) 1920.

In most illnesses protein metabolism is disturbed. In acute infections, there is an increased catabolism of protein. In diabetic acidosis, we find an increased demand due to the loss of proteins—which may be considerable. Minot [7] says that defective nutrition can arise when the diet seems adequate, because of some disturbance in the gastro-intestinal tract and its contents which may act adversely so as to "condition" or enhance a deficiency within the body proper.

This is readily understood when we know that a protein deficiency of itself may lead to an edema of the intestinal mucosa causing poor intestinal absorption. This leads to a greater protein deficiency,[8] thus completing the vicious cycle.

Protein loss is a well-known complication of burns and a factor in the physiology of kidney disease. In convalescent care, it is important to administer, as early as possible, sufficient protein to replace the loss caused by the serious injuries, burns, or other pathologic conditions. There must also be sufficient carbohydrates and fats to provide for the caloric requirements of the individuals so that the protein can be utilized for rebuilding tissues and for healing, rather than for energy purposes.[9]

PROTEIN AND ULCERS

A review of the relevant literature indicates clearly that a low protein diet will always produce an ulcer in the fore-stomach of rats [3, 10] and in the stomach of dogs [11] in a very few days. Dr. Co Tui, of New York University, has found that there is a more striking remission of peptic ulcers following treatment with a high protein, high caloric and high vitamin diet than is observed in those patients on a Sippy diet. Dr. Co Tui gives from 0.5 to 0.2 gram of nitrogen per kilogram of body weight, and 40 to 50 calories per kilogram in his diet.

On the other hand, a Sippy diet for a 70 kilogram man provides for one-sixth the protein and one-half the calories that are furnished in Co Tui's minimum diet. In the later stages, the Sippy diet doubles the protein intake and increases the caloric intake. But this still does not approach Co Tui's minimum.

Dr. Bacon Fo Chow's minimum diet provides 0.68 gram of nitrogen per kilogram. The high caloric requirement is furnished by the dextri-maltose and sugar used with the protein hydrolysate.

This is regulated for each individual case. We have also used a high vitamin diet with especial emphasis on vitamin A. We have prescribed 25,000 units (fifty times the normal requirement) daily, and have at times found it necessary to furnish vitamins as follows:

Thiamin—5 milligrams or five times the normal intake.
Nicotinic acid amide—150 milligrams or ten times the normal intake.
Riboflavin—5 milligrams or twice the normal intake.
Ascorbic acid—150 milligrams or twice the normal intake.
Vitamin D—One thousand units, slightly higher than the normal intake.

REPORT OF CASE 1

The first case is one of peptic ulcer in a man who also had a four-plus Wassermann. Response to protein hydrolysate was dramatic.

Complaints: A 25-year-old male was admitted to the Perth Amboy Hospital complaining of pain in the right lower quadrant, nausea and vomiting.

History: The pains started a month prior to admission. He had been in the Navy, and while in service was treated for "stomach trouble". This occurred more than a year before the present illness.

Physical Examination: Patient appeared well nourished. No masses were palpable in the abdomen, and while there was some rebound tenderness over McBurney's point, there was no rigidity in the right lower quadrant. There was, however, some slight tenderness in the right upper quadrant. Otherwise, clinical examination was negative.

Laboratory Reports: The red cell count was 4,769,000, hemoglobin was 88 per cent. White cell count was 7300. Urine was negative except for a "trace" of albumin. The blood Wassermann was four-plus. A stool examination (at second admission) showed occult blood.

Roentgenogram: The x-ray report was: "There is a marked degree of chronic hypertrophic gastritis. There is a prepyloric ulcer with moderate dilation of the body of the stomach due to the ulcer. The cap is small and spastic. Diagnosis is prepyloric obstructive gastric ulcer."

Course: On a Sippy regime, the patient improved for a while, and after six days of this diet he was

7. Minot, G. R.: Am. Int. Med., 12:42 (Oct.) 1938.
8. Jones, C. M.: New Eng. J. Med., 215:1152 (Dec. 17) 1936.
9. Peters, J. P.: Federation Proc., 3:197 (Sept.) 1944.
10. Hoelzel, F., and DaCosta, E.: Proc., Soc. Exper. Biol. & Med., 29:382 (Jan.) 1932.
11. Weech, A. A., and Paige, B. H.: Am. J. Path., 13:249 (March) 1937.

released from the hospital, only to return a month later complaining of severe epigastric pain. This had begun eight hours prior to the second admission. He reported that he was unable to follow the Sippy regime at home because, after a while, milk and cream began to nauseate him. The day before admission he had had a coal black stool, and a few hours before entering the hospital he had vomited coffee-ground material.

Protein hydrolysate was recommended but ten days elapsed before this could be obtained, and during that ten-day period, he was placed on the Sippy regime. An x-ray at this time was reported as follows: "A gastric ulcer is present on the lesser curvature of the pylorus. There is slight gastric retention. The cap is small and fills fairly well."

Treatment with Hydrolysate:* First feeding consisted of three ounces (90 cubic centimeters) of a mixture of protein hydrolysate, dextri-maltose and sugar given in pineapple juice every hour for ten feedings. One dose was given just before he went to sleep. Water was given freely and vitamins were administered in high dosage.

Results of Treatment: The patient's weight, which was 139 pounds on the first day of this program, had reached 152 pounds on the 28th day. He began to feel better on the third day, and on the seventh day the roentgenologist reported "no evidence of an ulcer". He had his first supplementary bland breakfast on the 20th day and an additional bland dinner on the 25th day. He was discharged on the 25th day and three days later he was reexamined and his condition was found good.

Comment: This patient apparently could not follow the Sippy regime. He was awakened at night by epigastric pain, and the resultant insomnia plus the persistent nausea made the Sippy diet impractical. In any event, the Sippy regime failed to produce lasting relief, whereas the ulcer disappeared roentgenologically on the protein hydrolysate diet. The treatment finally followed was that suggested by Dr. Chow of E. R. Squibb and Company. It consisted essentially of eight to ten daily feedings of 3 to 4 ounces of protein hydrolysate mixed with sugar and dextri-maltose. The hydrolysate supplied all the nitrogen (protein) required, i. e., 0.6 grams (10 grains) of nitrogen per kilogram of body weight. This amounts to four grains of nitrogen per pound of body weight per day. The necessary carbohydrates and minerals were supplied by the sugar and dextri-maltose. Of these, an amount at least equal in weight to the quantity of hydrolysate was used.

Dosage: The amount of protein hydrolysate is calculated at 2 grams (30 grains) of hydrolysate per pound of body weight per day. One feeding is given on arising, one on going to sleep, the others being distributed throughout the day for a total of eight to ten feedings. No other foods are given while the patient is on this intensive treatment, though high vitamin intake is maintained.

Plasma Protein: In this case, the total plasma protein increased slightly during the hydrolysate diet. Before feeding was begun the total plasma protein concentration was 6.75 grams per cent while three weeks after initiation of treatment, the figure was 7.00 grams per cent. Plasma volume also increased.

* The protein hydrolysate used in these cases was supplied by E. R. Squibb and Company.

REPORT OF CASE 2

The second patient was a 69-year-old man. While the ulcer persisted radiologically, clinical improvement on hydrolysate was marked.

Complaints: This 69-year-old man was admitted on February 13, 1946, to the Perth Amboy General Hospital, complaining of epigastric pains (of five years duration), of loss of weight (eighty pounds during the last year) and of vomiting and anorexia. He had been under treatment for gastric ulcer without results since 1941.

Physical Examination: He was a frail, obviously undernourished old man in some distress. Except for a questionable rigidity in the epigastrium, physical findings were substantially negative.

Laboratory Reports: Blood sugar was 171, nonprotein nitrogen was 66. Urine showed "one-plus" albumin, with occasional hyaline casts. Red cell count was 3,850,000, white cells numbered 35,650, hemoglobin was only 62 per cent.

Roentgenogram revealed presence of a gastric ulcer.

Course: He was in poor condition on admission and needed and received intravenous saline and a blood transfusion. Penicillin was administered at the rate of 30,000 units every three hours for sixty doses (to control the pneumonic process at the base of the left lung). His temperature, which was 103.8° on admission, dropped to normal after a pleural effusion was located and aspirated. He remained on a Sippy regime for 34 days with no marked improvement. Protein hydrolysate diet was then initiated.

Treatment with Hydrolysate: On the 35th day after admission he began receiving the hydrolysate diet. Within 48 hours the abdominal distress had vanished. Within a week he had gained ten pounds. A week later he showed an additional gain of eight pounds. On the 21st day of the hydrolysate program, he weighed 140 pounds, contrasted with a weight of 121 at the start of this regime. Although x-ray showed persistence of the ulcer, he felt well, and was discharged in good condition.

Comment: This elderly patient showed no improvement after 34 days of Sippy regime,

yet had no clinical complaints within 48 hours after initiation of the hydrolysate diet. He originally had a hypo-proteinemia, but this also disappeared on treatment. Before the first hydrolysate feeding, his protein concentration was 5.19 grams per cent. Three weeks later it was 6.39 grams per cent.

REPORT OF CASE 3

This was a 60-year-old man who had had an ulcer history for a year prior to admission. Sippy diet failed to effect relief, but hydrolysate removed his complaints within 48 hours.

Complaints: This 60-year-old man was admitted to the Perth Amboy General Hospital complaining of epigastric pain, nausea, belching, and dyspnea. The gastro-intestinal symptoms were not relieved by eating.

Physical Examination: This patient was well nourished. His heart was in fibrillation but no murmurs were audible. The epigastrium and lower right quadrant were tender. Otherwise examination was negative.

Laboratory Reports: Urine was normal except for "one-plus" albumin. White cell count was 14,150, red cells numbered 5,240,000 and hemoglobin was 114 per cent. A trace of occult blood was found in the stool.

Roentgenogram disclosed the presence of a duodenal ulcer.

Course: He was digitalized and placed on a Sippy regime. This failed to relieve his complaints and after a week it was replaced by a hydrolysate diet. Within 48 hours he felt much better. While the ulcer was still visible on x-ray at the conclusion of the hydrolysate diet, clinically the patient was vastly improved. His protein concentration was 6.81 grams at the end of the first week, and had risen to 7.81 grams at the end of the third week of the hydrolysate regime.

SUMMARY

1. In three patients with peptic ulcer, a protein hydrolysate diet was able to effect marked improvement when a Sippy regime had failed. The improvement on the hydrolysate program was noted within 48 hours after initiation of the diet.

2. In all three cases, protein concentration was increased at the end of three weeks of treatment. Protein volume was also increased.

3. In two cases, the ulcer remained radiologically visible at the end of treatment; in one case, the ulcer disappeared within a week.

4. The hydrolysate is given in the form of a mixture of dextri-maltose, sugar and protein hydrolysate in pineapple juice. Vitamins are administered in high dosage. The amount of hydrolysate is 30 grains (two grams) per pound of body weight (or 4.4 grams per kilogram). One feeding is given on arising, one on going to sleep, the others being distributed throughout the day to a total of eight to ten feedings.

5. Proteins have acid-binding properties and represent logical medication for peptic ulcer. Proteins in the form of amino acids (hydrolysate) are advantageous because of their swift absorption and utilization by the body.

280 Hobart Street
530 New Brunswick Avenue

SPECIALISTS IN VA PROGRAM

If you are participating in the VA personal-physician treatment program, and wish to be listed as a specialist, entitled to specialist's fees, submit the following information to Dr. Edward T. Yorke, room 316, Veterans Administration, 20 Washington Place, Newark 2, N. J.

(a) How long you have been practicing the specialty, and what specialty? (b) Board certification if any; (c) Fellowship in A.C.S., A.C.P. or comparable national specialty organization; (d) Hospital staff appointments with rank and title; (e) Other qualifications including graduate courses, residencies, etc.

INTRAVENOUS TREATMENT OF TETANUS

Edward S. Balles, M.D., Paterson, N. J.

A twelve-year-old boy was admitted to Paterson City Hospital with rigidity of the neck, inability to open his mouth, forearms flexed on his upper arms, boardlike abdomen, arched back and flexed legs. There was a small, red, edematous abrasion on the left upper leg six centimeters from the kneecap. Temperature on admission was 99.4 and the pulse was 90.

The following treatment was given: 40,000 units of tetanus antitoxin were given intravenously and a cubic centimeter of adrenalin subcutaneously. It was necessary to have help to extend the arm to give the intravenous injection.

In twenty-four hours, rigidity had left the arms and the jaws had relaxed enough so that the patient could place a straw between his teeth and take fluids.

For the next four days, at twenty-four hour intervals, the patient received 40,000 units of tetanus antitoxin intravenously, and adrenalin subcutaneously. Magnesium sulphate enemas were used to evacuate the bowels. There was no suppression of urine.

Rigidity of the legs slowly left, and, by the fifth day, the patient could extend the legs completely, and could place one finger between his teeth. The abdomen remained boardlike for ten days.

The rigidity of the neck and back had disappeared by the seventh day. The trismus left by the ninth day. The patient was discharged on the tenth day. He remained in bed for two weeks at home.

Summary: (1) No spinal taps were done. (2) For the first five days, 40,000 units of tetanus antitoxin were given intravenously at twenty-four hour intervals. (3) During the second five days, injections of 10,000 units of tetanus antitoxin were given intravenously at twenty-four intervals. (4) All injections were followed by one cubic centimeter of adrenalin (1:1000) subcutaneously. (5) Elixir of phenobarbital, one drachm, was given three times a day for spasm.

Conclusion: Intravenous treatment of tetanus with antitoxin appears to be an effective method of treatment in advanced stages.

392 Park Avenue

THE MYTH OF RAGWEED ERADICATION

Community campaigns to eliminate ragweed for the relief of hayfever sufferers are a waste of time and effort, according to the September 7 issue of *The Journal of the American Medical Association.*

Permanent riddance of ragweed from any community in which it is well established is impossible, because of the longevity and abundance of viable seeds in the soil. Annual riddance can be accomplished by uprooting the weeds, but recent experiments have shown that chemical destruction is entirely feasible. Destruction of the weeds during one season will not appreciably affect the presence of weeds the next season, nor will complete destruction of ragweeds before the time of shedding of pollen prevent toxic amounts of pollen being blown into the community from areas as far away as 75 miles.

Apparently successful weed destruction campaigns have been carried out in a few places, but in only one instance have control tests of the air been made before, during and after the campaign in order to determine its effectiveness. In Sault Ste. Marie, Mich., and Bar Harbor, Maine, in past years local efforts have been directed toward ragweed destruction and have been deemed successful, though no atmospheric tests were made. Since both these places are well insulated it should be possible by diligent weed destruction to reduce the pollen content of the air very considerably. In Chicago, control tests carried on during a three-year campaign showed a higher total pollen content of the air each year during which the campaign was carried on. There is no hope of reducing the pollen content of the upper air by local weed eradication in a community surrounded by millions of acres of ragweeds in farm lands.

STATE ACTIVITIES

MEDICAL FEES IN COMPENSATION CASES

At the September 29 meeting of the Board of Trustees the following resolution of the Welfare Committee, adopted September 15, was concurred in: "That insurance companies be approached relative to the fees for compensation cases being placed on a par with fees charged the average private patient and the fee schedule of the Veterans Administration." The Trustees referred this matter to the Chairman of the Workmen's Compensation Committee with power to act.

At the annual meeting of the Board on April 21 a communication from Dr. Harryman, Chairman of the Workmen's Compensation Committee, was presented. The Board concurred in the opinions of Dr. Harryman and instructed that the contents of his communication be published in the Journal. The letter follows:

February 19, 1947.

From: Chairman, Committee on Workmen's Compensation.

To: Acting Executive Officer, The Medical Society of New Jersey.

In regard to increase in fees to be charged insurance companies for the care of workmen's compensation cases I have recently been in touch with several of the leading insurance men in Newark.

There are three main groups of representatives of the various insurance companies none of whom have the power to set a definite fee. There are some sixty-eight insurance companies altogether and it would seem to be impossible to get a universal agreement among all of them. The Medical Society of New Jersey has always fought against a fee schedule. The fees charged at the present time are more or less by agreement and there is actually no fee schedule. The law specifically says in regard to fees that "The fee to be charged should be in accord with the prevailing fee charged for similar treatment in that particular location". At the present time, certainly, in northern New Jersey, the average office fee charged for the ordinary office visit by most of the men is three dollars. The Veterans Administration allows three dollars. Several of our County Societies have passed resolutions recommending that their members charge similar fees to compensation cases.

I contacted a head of one of the leading insurance companies in Newark and we discussed the matter of which group to bring this subject up to and he felt it would be hopeless to bring it up to any of them, for as previously said,, none of them have any power to approve or disapprove increased fees. He also told me that in a number of smaller municipalities these increased fees are already being paid by the insurance companies without protest.

He recommended that it be left to the individual doctors to bill the insurance companies for what they felt is a fair fee commensurate with the services rendered in similar cases in their locality. If some of the insurance companies protested, this matter would be appealed later.

After thinking it over very carefully I believe he has the right solution. If there is a protest arising concerning the fee charged by the individual doctor, then it would be up to that doctor to prove that he got the same fee for his private cases. I think also that it should be called to the attention of physicians that if they are to get an increase in their fee they should be doubly careful that these cases not be over-treated, as I think it is this that annoys the insurance companies more than the actual size of the individual fee.

I believe that this matter of increased fee can be equitably adjusted without any particular trouble with the insurance company as I personally have found most of them very cooperative as long as they felt they were getting fair services in return for their payments.

I would, therefore, as Chairman of the Workmen's Compensation Committee, recommend that the above recommendations be published in the Journal so that it may be brought home to the general practitioner that if he wants an increase in his fees bringing them to the same level as his private cases then it is up to him to cooperate in holding the number of visits to the minimum, continuing to give good services to these compensation cases and keeping the insurance companies up to date with reports as to what is going on.

I believe that it might be of great help if each individual County Society took appropriate action in regard to this increase in fees.

By doing so there would be less likelihood of a certain few men offering to do this type of work at cut rate figures. As you know, several counties have already taken this action.

Very truly yours,

(signed) William K. Harryman, M.D.
Chairman, Workmen's Compensation
Committee.

1947 ANNUAL MEETING OF THE HOUSE OF DELEGATES

ABSTRACT

1. Transactions of 1946 House of Delegates approved as published with the August, 1946, JOURNAL.

2. Reports of Officers and Committees:

a. President—approved as published, April 1947 JOURNAL.

b. Secretary—approved as published, April 1947 JOURNAL.

c. Board of Trustees—approved as published, April 1947 JOURNAL.

d. Judicial Council—approved as published, April 1947 JOURNAL.

e. Treasurer—approved as presented, April 22, 1947.

f. Finance and Budget—1947-48 budget in amount of $82,770. approved as presented April 22, 1947.

g. 1948 dues—approved at $20.00 per member.

h. Publication Committee—approved as published, April 1947 JOURNAL.

i. State Board of Medical Examiners—approved as published, April 1947 JOURNAL.

j. Military Service Committee—approved as published, April 1947 JOURNAL.

k. Medical Service Administration and Medical-Surgical Plan—approved as published in April 1947 JOURNAL and in supplementary report.

l. Veterans Liaison Committee—approved as published in April 1947 JOURNAL with following recommendation:

That before the contract between Medical Service Administration and Veterans Administration is renewed in June it shall be carefully reviewed and amended as necessary to assure: (1) free choice and free choice only of physician by the veteran when not treated in Veterans Administration installations, (2) that the contract be amended so as to assure the efficient and effective administration by our liaison officer.

Recommendation adopted

m. Post Graduate Education Committee—approved as published, April 1947 JOURNAL.

n. Scientific Work Committee—approved as published, April 1947 JOURNAL.

o. Advisory Committee to Woman's Auxiliary—approved as published in April 1947 JOURNAL and in supplementary report.

p. Medical Defense and Insurance Committee—approved as published April 1947 JOURNAL. Supplementary report and recommendations as follows approved:

1. That each county society maintain a medical defense and insurance committee, which shall be a standing committee, the personnel of which should be appointed for a term of three to five years.

2. Renewal of the contract with U. S. Fidelity and Guaranty Company through our official broker, Faulhaber and Heard, Inc., whose offices shall maintain records of all communications and transactions for the committee.

3. That the President and Secretary of the Society be authorized to execute an amendment to our master agreement on accident and health with the National Casualty Company, providing for an increase of maximum monthly indemnity from $300 to $400; also providing for an additional $5000 dismemberment indemnity in those policies carrying $300 per month indemnity for an additional premium of $1.00.

4. That the contract with E. and W. Blanksteen Agency be renewed.

q. Subcommittee on Legislation—approved report as published, April 1947 JOURNAL and supplementary report with the following recommendations:

1. Several representatives of the State Society, including the President, be sent to the hearings in Washington on the Taft-Smith-Ball-Donnell Bill.

2. Senators Taft and Fulbright be informed of the disapproval by the State Society of their bill, as it does not agree with the aims of organized medicine.

r. Subcommittee on Public Relations—approved as published, April 1947 JOURNAL.

Urge that continued efforts be made to evolve a speakers bureau; executive officer to be ex-officio Executive Secretary of committee.

s. Subcommittee on Public Health—approved as published, April 1947 JOURNAL.

t. Subcommittee on Medical Practice—approved as published, April 1947 JOURNAL.

u. Advisory Committees—approved as published with the following commendations and recommendations:

1. Child Health—concur in five point program.

2. Conservation of Vision and Hearing—recommend committee continue efforts in limiting activities of certain optometrists in prescribing glasses for school children.

3. Maternal Welfare—recommend continuation of four point program.

4. Mental Hygiene—recommend continuation of five point program; emphasize that it would be wise to place a psychiatrist at the disposal of each county superintendent of schools or of such groups of coun-

ty superintendents of schools, as would be adequate to meet the needs of these populations.

5. Nutrition—commend program of committee and recommend activity be continued.
6. School Health—commend five point program and recommend it be continued.
7. Tuberculosis—commend seven point program.
8. Venereal Disease Control — recommend careful study of the problem of teaching sex hygiene and do not by any tactless approach antagonize any group of parents in our communities.
9. Hospital Relationships—agree that there should be more members on hospital boards of trustees and that internship standards should be raised as rapidly as possible throughout New Jersey so that our graduates may equal those of hospitals with teaching institutions.
10. Industrial Health and Hygiene—urge committee's continued participation in the projects of the American Academy of Occupational Medicine.
11. Laboratory Medicine—urge committee to continue activities.
12. Nursing and Nursing Education — urge committee to continue cooperation in formulating standards of the proposed revision of the Nurses' Practice Act.
13. Physical Medicine—agree that departments of physical medicine should be under the direction of a physician trained in physiotherapy.
14. Workmen's Compensation—urge committee to publish revised "Suggestions for the General Practitioner", and agree that fee bases should be established on a county level by county Workmen's Compensation Committees.

v. Annual Meeting Committee—approved as published, April 1947 JOURNAL.

w. Subcommittee on Scientific Program—approved as published, April 1947 JOURNAL.

3. Amendments to the Constitution and By-Laws:

a. Constitution, Article IV, Section 5; final approval.

Honorary members shall be physicians and surgeons who have attained distinction within the medical profession, *or non-medical persons who have rendered signal service to The Medical Society of New Jersey or who have attained special eminence in scientific fields other than medicine,* . . . . . .

b. Constitution, Article IV, Section 7—for final approval in 1948.

The emeritus membership group shall include physicians who have been members in good standing of a component county society for at least twenty (20) years, and who by reason of age or infirmity have retired from the active practice of medicine, or members of the society who have been disabled by reason of military service. They shall have all the privileges of membership except the right to vote and to hold office, but their respective component societies shall not be assessed for such members, provided they are carried as emeritus members in their component societies. The emeritus members shall not be included in the membership of a component county society when computing the number of delegates that such society is entitled to.

c. By-Laws, Chapter 6, Section 5, item (b) —Term of Office of Trustees—Disapproved.

4. Resolutions and Memorials.

a. Resolution re Dr. Alfred Stahl and presentation of Society key—approved.

b. Resolution from Essex County concerning socio-medical indoctrination of medical students and recent medical graduates by a program of intracurricular or other instruction to be sponsored and carried out by the A. M. A.

Resolution approved; instruct delegates to the A. M. A. to present resolution at the next executive session of the A. M. A.

c. Resolution re Mr. John S. Thompson as honorary member of this society—approved.

d. Recommendation for the resumption of the Fall Clinical Conference in 1947, that Bergen and Passaic Counties be responsible for the meeting, and that an Elias J. Marsh Oration be held on the last night—approved.

e. Recommendation that the 1948 Annual Meeting be held at Haddon Hall in May or the last week in April, the exact time to be determined by the Board of Trustees—approved.

f. Monmouth County Resolution — following recommendations approved:

1. The House of Delegates direct the President to appoint a Committee of seven (7) to crystallize the mechanism of approach to the problem of providing good medical care for every citizen of New Jersey;
2. The American Medical Association, the State and County Societies follow through on the newly created policies on Public Relations of the A. M. A.;
3. Support the New Jersey Health Congress.

g. Resolution re Fees from Insurance Companies (Tennessee Plan)—approved with recommendation that the fee for life insurance examinations be raised to $10, with all other medical insurance fees to be increased in like proportion; copy of resolution to be sent to insurance companies listed.

h. Resolution on Compensation Fees—recommendation that this be solved on the county unit basis by the various Workmen's Compensation Committees, approved.

i. Recommendation re Dues of Veteran Medical Officers—

1. That all veteran medical officers who were members in good standing of The Medical Society of New Jersey at the time of entrance into military service shall be entitled to one full year's credit or remission of dues in addition to remission of dues during the balance of the year he was discharged, approved.

2. That the State Society remit the dues of those veteran members who are taking fulltime graduate training under the G. I. Bill of Rights and who are not in the private practice of medicine, disapproved.

j. Recommendations of Reference Committee "A" re office of Acting Executive Officer and office of Secretary referred to Board of Trustees.

5. Election:

OFFICE	TERM	
President-Elect	(1 year)	J. Howard Hornberger
1st Vice-President	(1 year)	James F. Norton
2nd Vice-President	(1 year)	Aldrich C. Crowe
Secretary	(1 year)	Earl LeRoy Wood
Treasurer	(1 year)	George J. Young

TRUSTEES

1st District	(3 years)	William F. Costello
2nd District	(3 years)	Joseph G. Coleman
	(1 year)	Sigurd W. Johnsen
3rd District	(3 years)	George W. Fithian
	(1 year)	L. Samuel Sica
5th District	(3 years)	David B. Allman

COUNCILORS:

1st District	(1 year)	Francis C. Weber
2nd District	(3 years)	Vincent P. Butler
5th District	(3 years)	Chester I. Ulmer

A. M. A. DELEGATES AND ALTERNATES (1948 AND 1949 MEETINGS):

Delegate	(2 years)	Joseph F. Londrigan
Alternate	(2 years)	Ralph K. Hollinshed
Delegate	(2 years)	William F. Costello
Alternate	(2 years)	Thomas J. Walsh
Delegate (1947-1948 meetings)	(1 year)	J. Wallace Hurff

DELEGATES AND ALTERNATES TO OTHER STATES (1948 MEETINGS):

Delegate (New York)	(1 year)	James F. Norton
Alternate	(1 year)	D. Ward Scanlan
Delegate (Connecticut)	(1 year)	Alfred Stahl
Alternate	(1 year)	C. Byron Blaisdell

STANOING COMMITTEES:

Finance and Budget	(5 years)	Anthony J. Conty
	(3 years)	Luke A. Mulligan
Publication	(3 years)	J. Lawrence Evans

SCIENTIFIC WORK:

4th District	(5 years)	S. Emlen Stokes

MEDICAL-SURGICAL PLAN OF NEW JERSEY

As of April 30, 1947, there were 104,840 persons enrolled under effective contracts, with an additional 3,767 persons enrolled under contracts with future effective dates for a total enrollment of 108,607 persons.

The earned subscription income for the month of April was $70,700.17. The claims incurred had a value, in accordance with the Plan's schedule of benefits, of $55,946.50.

BENEFITS FOR ANESTHESIA

A readjustment of the amount of benefits payable for the administration of anesthetics has been under consideration by the Board of Trustees of the Plan for some time. Further consideration awaits a requested conference with representatives of the New Jersey Association of Anesthetists.

The Plan desires to pay benefits on as broad a basis as possible, and in the fairest amounts possible for any eligible services, consistent with sound financial management of the Plan. In determining the amount of benefit payable for any eligible service the law of averages is just as applicable as it is when considering the percentage of enrollment acceptable by the Plan.

A case in point is our recent experience with a new item on our schedule, "Intratracheal Anesthesia, $25.00". This item became effective in November, 1946, in an effort more nearly to meet the needs of our subscribers when intratracheal anesthesia is necessary. Under this item the Plan is receiving claims for intratracheal anesthesia in such cases as perineorrhaphy, inguinal hernia repair, appendectomy, etc. This is not consistent with the law of averages and has made it necessary for the Trustees of the Plan to define the eligibility of intratracheal anesthesia. The Board defines its eligibility as follows:

> Intratracheal anesthesia will be considered as an eligible service "when administered in cases of brain surgery, thoracic surgery, thyroid surgery and in upper abdominal and gastro-intestinal surgery where poor airway is encountered under other forms of anesthesia".

In accordance with the above definitions, anesthetists are requested to submit on their statements to the Plan the indication for intratracheal anesthesia when this type of anesthesia has been administered.

No endeavor, business or profession can be assured of long life these days, as a private enterprise, except on the basis of sound philosophy and integrity. The philosophy of the Medical-Surgical Plan is the expressed philosophy of the medical profession. Its integrity is dependent to a large extent upon the integrity of the individual physician. The Plan is willing, at all times, to discuss any phase of its work with any group of interested physicians.

The Plan aims at all times to operate within the framework of our present methods of practice, and according to the expressed policies, traditions and ethics of the profession.

Consistent with this the Board of Trustees of the Plan believes that the patient is entitled to know the cost of a physician's service at the time the service is requested.

The Board suggests that when a patient, not entitled to full service benefits in accordance with the schedule of benefits of the Plan, requests the services of a Participating Physician, that the patient and physician agree at this time on the amount of any additional payment to be made.

A pamphlet of information has recently been mailed to every physician in New Jersey. Additional information may be obtained by addressing the Plan at 31 Clinton Street, Newark (2), New Jersey. Phone MItchell 2-0675.

VETERANS CARE PLAN†

NO AUTHORIZATION, NO TREATMENT

A great change has taken place in the administration of the home-town medical care program for veterans having service-connected defects. No physician should use his experience of a few months ago as a guide to his dealings with the Veterans Administration at this time.

Physicians were informed in this JOURNAL in March not to make any diagnostic surveys of veterans without having written authorization from VA. A bulletin is being released to all physicians stating that "the Veterans Administration is not responsible for services rendered by a fee-basis physician *unless an authorization to perform such services at government expense has been issued.*"

An emergency is an exception. But, the physician or the veteran should telephone VA for a verbal authorization for treatment, according to the bulletin. The physician should establish a clear understanding with the VA in his phone conversation just how much treatment he will be authorized to administer. He should also make a written memorandum to the VA office regarding his conversation and the amount of treatment orally authorized.

WHAT THE VETERAN MUST DO

With the single exception of acute emergencies, the veteran is to be referred to the nearest VA office when he seeks out-patient medical care by his private physician.

The bulletin issued by VA will be useful to the physician in his relations with veterans, for the new policy is plainly expressed. Always difficult to decide, the question of service-connection *must be settled by VA before veterans go to their private physicians* for medical care at government expense.

VETERANS ALREADY UNDER TREATMENT

So long as the physician has written authority to treat a veteran at VA expense, the procedure will not be affected by the new policy. He will be informed to request new authority for the next additional period of treatment, preferably by the 23d of the month so that VA will have time to issue the authority by the beginning of the next treatment period. There is always the possibility that VA will decide to take over treatment of the veteran; hence physicians should wait for authority before continuing treatment.

TREATMENT IN VA CLINICS

VA has been ordered to use its own facilities to the maximum in the treatment and examination of veterans. An effort will be made to get as many veterans as possible under treatment in VA clinics. VA has been ordered to examine veterans who are under treatment by private physicians to determine their status and need for further treatment.

VA is not in a position to treat all the veterans in this state. It is not possible to give an estimate of the portion VA will be capable of treating.

FREE CHOICE OF PHYSICIAN

The home-town medical-care program as conceived by Dr. Hawley will continue in effect for those veterans who are not under treatment in VA stations, and veterans will have free choice of physician.

The contract between Medical Service Administration and VA, which established provision of wide choice of physicians for disabled veterans, automatically terminates on June 30th, but will be renewed or renegotiated.

INCOME LIMITATION

Physicians will be limited to an income from VA of $6000 per year.

QUESTIONS AND PROBLEMS

The bulletin released by VA to physicians may raise certain questions. Physicians are advised to communicate with the undersigned at Extension 457 (MArket 3-6800), inasmuch as the Medical Society representative desires a well-rounded opinion as afforded by letters * from physicians concerning the VA medical-care program for disabled veterans.

PENSION UNITS

VA has discontinued the use of the facilities of the Plans established by county medical societies for making pension examinations. A total of 1656 cases was sent to units in Hudson, Middlesex, Bergen, Passaic, Ocean and Warren-Hunterdon counties. The number of cases sent to Monmouth Plan cannot be obtained from VA sources.

EDWARD T. YORKE, M.D.,
Liaison Officer.

† Attention is also directed to the boxed item on the bottom of page 231, this issue

* Address: Dr. Edward T. Yorke, Liaison Officer, Room 316, 20 Washington Place, Newark 2.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

Protection of Newborn Infants in Hospital Nurseries

Deaths in the first week of life represent more than half of the deaths occurring in infants under one year of age. Since almost 90 per cent of all births are now occurring in hospitals any reduction in the deaths in the first weeks of life must come from the hospitals, particularly from the obstetrical and newborn nursery services.

A committee of the American Academy of Pediatrics after studying the various diarrheal conditions which may occur in hospital nurseries made the following observations:

"An infant in the neonatal period who, previously well, suddenly passes one or more loose or liquid stools combined with sudden abnormal loss of weight (after the period of initial weight loss) or one of the other symptoms associated with this type of diarrhea such as vomiting, listlessness, drowsiness, refusal of feeding, short feeble cry, pallor, elevation of temperature, should be immediately isolated and reported to the hospital authorities as a suspected case of infectious diarrhea."

"Since there is no definite way of establishing the identity of the disease the development of similar symptoms in another exposed infant will make it essential to report both the suspect case and the new case to the health department."

Although infectious diarrhea of the newborn was made reportable in 1943, there have been instances in which the existence of the disease in hospitals was first discovered in a study of death reports. In a disease presenting such obvious diagnostic difficulties and which often has a fatality rate as high as 80 per cent it would be safer to establish control measures as soon as any case of diarrhea occurs in a hospital nursery thereby making less serious the delay in recognizing the epidemic type.

Every hospital with a maternity service should provide:

(1) A nursery for well infants.

(2) A "suspect nursery" to which the nursing staff may transfer infants whenever signs or symptoms develop of illness or infection, such as fever, loose or frequent stools, eye, skin or vaginal infection.

An uninfected case may be returned to the well infant nursery on authority of medical staff.

(3) An isolation nursery to which infants are removed when the medical staff has definitely established the case as infectious.

These units should be equipped to provide individual care. Ideally each should have independent nursing, medical, and other personnel.

Infants should be examined in an examining room apart from the nursery. Entrance into the nursery should be limited to personnel giving nursing care and to cleaners unless an emergency requires others to enter.

All who enter the nursery units should observe the same regulations. Gowns should be worn. Masks are optional with the medical and nursing staff.

Aseptic technic should be observed, and hands should be washed between contacting individual babies, especially after changing diapers and before handling bottles and before feeding.

Avoid common supplies such as thermometers, cotton, oil, etc. Babies should receive all care in their bassinets and common bathing and dressing tables should be avoided. Scales should be individually draped for use. All bedclothing, clothes, and diapers should be autoclaved before use.

The formula room should be so arranged and conducted that the possibility of contamination of materials, utensils and formulas is reduced to a minimum.

Standards that have been adopted for lying-in institutions and newborn nurseries may be obtained by writing to the State Department of Health, Trenton, New Jersey.

The Division of Maternal and Child Health is especially interested in diarrheal conditions in newborn nurseries. Their staff is available for consultation and advice regarding medical and nursing procedures in newborn nurseries and they will be glad to assist in the recognition of epidemic diarrhea and in the establishment of control measures.

Because the results of the treatment of epidemic diarrhea are so variable, it is important to do everything possible to prevent its occurrence.

Penicillin Treatment of Syphilis

At a recent meeting in Washington reports were given by syphilologists who are carrying on research in penicillin treatment under the direction of the National Institute of Health.

Variations in the scheme of treatment with penicillin solutions are being used in different centers throughout the country and from the reports given there seems to be general agreement that the dosage in use in New Jersey of 2,400,000 units is satisfactory. The New Jersey plan concentrates this treatment in five or six days which is a shorter time period than that followed in most other states. There is not enough evidence of better therapeutic results with a longer time period to warrant the expense of longer periods of hospitalization. The use of penicillin for treatment of syphilis in the same time-dosage schedule as at present will be continued.

The Diagnosis of Syphilis in Infants

Several requests for permission to treat infants of syphilitic mothers under the state penicillin treatment plan have led to the preparation of the following recommendations.

In general, a definite diagnosis of syphilis, based on clinical symptoms or on serology, should be made in the infant before treatment is given. Only the infants of syphilitic mothers whose syphilis is of less than one year's duration should be treated without an accurate diagnosis; and then only when the mother has not received proper treatment before delivery.

A diagnosis of syphilis may be made on clinical symptoms but no suspected infant should be treated without practical proof of syphilis. If clinical signs and symptoms are absent, the diagnosis of congenital syphilis must be made on the course of serology. A diagnosis of syphilis cannot be made soon after delivery unless the blood of the infant, by quantitative tests, shows definitely more reagin than was found by a recent quantitative test of the mother's blood. If the titre rises markedly in a series of three blood tests in the infant, a diagnosis of congenital syphilis should be made. Qualitative tests are not reliable until four to six months after delivery.

REORGANIZATION OF STATE HEALTH DEPARTMENT

Assembly Bill No. 6 was signed by the Governor on May 22, 1947. The complete act appears in the June 1946 issue of *Public Health News,* and a free copy will be sent to any physician who writes to the Health Education Division, State Department of Health, Trenton 7, New Jersey. The following abstract of the Act was prepared by Mr. Fisher of the State Department of Health:

Article II establishes a State Department of Health. It provides that "The chief administrative officer of the department shall be the State Commissioner of Health, who shall be a duly licensed physician, a graduate of a regularly chartered and legally constituted medical school or college, with skill in sanitary science, and with at least five years of full-time experience in an administrative or executive capacity in a public health agency. He shall be appointed by the Governor, by and with the advice and consent of the Senate, and shall hold office for a term of five years and until his successor is appointed and qualified.

"He shall devote his entire time and attention to the duties of his office and shall receive an annual compensation of fifteen thousand dollars. He may be removed from office by the Governor, for cause."

"There shall be in the department, a Public Health Council which shall consist of seven members, each of whom shall be chosen with due regard to his knowledge of and interest in public health and each of whom shall be a citizen of this State. Two of such members shall be duly licensed physicians. Each member shall be appointed by the Governor, by and with the advice and consent of the Senate, for a term of seven years and until his successor is appointed and qualified; *provided, however,* that the first appointments hereunder shall be for terms which shall commence on the first day of July, one thousand nine hundred and forty-seven, and shall continue one for one year, one for two years, one for three years, one for four years, one for five years, one for six years and one for seven years. Any member of the Public Health Council may be removed from office by the Governor, for cause." Members of the Council serve without salary, but are reimbursed for expenses.

The Commissioner is authorized to establish and consolidate bureaux within the Department, subject to the approval of the Council.

Article III enumerates the powers and duties of the Council. It provides that it will meet monthly or as often as necessary, and instructs it to establish a state sanitary code after first holding a public hearing. Enforcement of the code is described in sections 8, 9 and 10 of this Article. The code will have the force and effect of law and it will be enforced by local boards of health, local police authorities and other enforcement agencies. Local boards of health may adopt added ordinances not in conflict with the state code.

In addition to other powers, Public Health Council may request information concerning the Department from the Commissioner; consider any matter relating to public health and advise the Commissioner; submit recommendations to the Commissioner regarding the Department; study public health activities in the state and report to the Governor and Legislature.

Local Boards of Health will file copies of their ordinances with the Commissioner. Public Health Council may modify or annul an ordinance of a local board of health if it concerns a matter which affects the public health beyond jurisdiction of local board.

Article IV describes the duties of the Commissioner. He will prescribe the organization of the department, with approval of the council; appoint personnel, fix their compensation (within limits of appropriations), and prescribe their duties, subject to approval by the Council. All appointments will be in the classified Civil Service unless otherwise provided by law. The Commissioner may abolish positions with council approval.

The article then continues as follows:

The commissioner, in addition to his powers and duties otherwise provided in this act or by any other law, shall:

a. Exercise all functions and powers of the department not specifically vested in the Public Health Council by this act;

b. Adopt rules and regulations governing the internal management of the department;

c. Administer the work of the department;

d. Enforce all laws relating to the health of the people of the state, and all provisions of the state sanitary code;

e. Administer all laws which are by their terms included under his jurisdiction or under the jurisdiction of the department.

f. Maintain liaison with local, state and federal officials and agencies concerned with matters of public health or otherwise related to the functions of the department;

g. Report to the Governor, the Legislature, and the Public Health Council, with respect to the work of the department, on March fifteenth of each year and at such other times as he may deem in the public interest;

h. Institute or cause to be instituted such legal proceedings or processes as may be necessary properly to enforce and give effect to any of his powers or duties as prescribed in this act;

i. Cause studies to be made to determine whether the recognized public health activities of local health departments are being conducted and whether minimum standards of performance are being met in all municipalities of the State and for the purposes of this subsection, the commissioner shall recommend and the Public Health Council shall prescribe what are to be considered as "recognized public health activities" and "minimum standards of performance";

j. Require local boards of health to establish and maintain a program of recognized public health activities and to meet minimum standards of performance as prescribed by the Public Health Council.

Sections 16 to 20 give the Commissioner access to any premises for examination on reason and confers the same right of inspection as provided for local boards of health. It authorizes the Commissioner to make sanitary surveys and inspection and provides that every local health official shall furnish information requested by the Commissioner and, within his jurisdiction, perform acts directed by the Commissioner.

The Commissioner is to call the attention of local boards of health to any failure to enforce state laws or sanitary code and after hearing, may issue order directing the local board to comply. If the Board fails to comply in time specified, the Commissioner may take action to perform the order and may incur expenses binding on the local municipality. The Department may recover any money expended by the state in action at law from the municipality.

If a local board of health fails to have a nuisance abated following notice from Commissioner, the Commissioner may file a bill in Court of Chancery for injunction. The same injunction power is authorized where the nuisance has a source outside the jurisdiction of a local board of health.

Sections 33 to 36 authorize the Commissioner (a) to have the state laboratory make analyses (b) to accept and administer grants (c) to accept the services of any local or federal agency, subject to the approval of the Council.

Article V assigns to the Department, the missions of "formulating comprehensive policies for the promotion of public health and preventive diseases," and calls on it to: prepare vital statistics; administer a state-wide program of health education; administer a public health nursing program, prescribe minimum qualifi-

cations of public health nurses for official public health work and encourage coordination of local public health nursing services; establish a state-wide unified plan for control of preventable diseases and encourage coordination of local programs; administer a program of maternal and child health services and encourage coordination of local programs; administer a dental health program and encourage coordination of local programs; maintain serologic, bacteriologic and chemical laboratories; administer a program of industrial hygiene, encourage establishment of medical, dental environmental engineering and nursing services in industrial plants; supervise sanitary engineering facilities and projects as authorized by law; enforce state and federal Food, Drug and Cosmetic Act; and to keep accurate minutes of hearings as permanent and public records.

Article VI provides for the examining and licensing by the Commissioner of health officers, and sanitary, plumbing, food and drug, milk and meat inspectors. The Public Health Council will prescribe qualifications. The Act provides for revocation of licenses when indicated.

(Senate Bill 206 which has also passed Senate and House prescribes further legislation for examination and licensing of health officers and inspectors.)

Article VII provides for hearings and investigations at the direction of the Commissioner when required by law. The Commissioner is authorized to subpena witnesses, books and papers and to provide penalty for failing to respond to a subpena.

Article VIII authorizes the Commissioner to establish health districts with the approval of the Public Health Council and to appoint a state health officer for each district who in addition to other duties within his district, will keep informed of the work of local health departments, aid local health officers in performance of duties, assist local officers in making the annual health survey, hold conferences of local health officers; adjust questions of local jurisdiction; study causes of excessive mortality from disease, promote registration of births and deaths, enlist the cooperation of organizations concerned with public health, disseminate public health information to the public, act as representative of the Commissioner and, under his direction, secure enforcement of state laws and sanitary code.

Terms of the present State Board of Health will expire June 30, 1947; also the term of the present State Director of Health will expire June 30, 1947, but he will continue in office until the appointment of a state commissioner of health.

Article IX provides for transfer of functions, powers and duties, appropriations and employees to the new State Department of Health. The Department will be provided with suitable quarters in one building.

"Section 67. This act shall not be construed to deny the right of a person, parent, guardian or custodian to treat or provide treatment for himself or an ill minor in accordance with the religious tenets of any church as is now or may hereafter be authorized by other statutes of this state, or to require any such person or any of his minor children to submit to physical examination other than as is now or may hereafter be required by other statutes of this state, or to require any such person or any of his minor children to submit to confinement in any hospital or medical institution other than as is now or may hereafter be required by other statutes of this state; *provided, always, however,* that the laws, rules and regulations relating to communicable diseases and sanitary matters are not violated.

Section 68. This act shall not affect powers, duties and functions of state Department of Labor or state Commissioner of Labor under any other provision of law."

BOOK REVIEW

Allergy. By Erich Urbach, M.D., and Philip M. Gottlieb, M.D. Second edition, pp. 968. New York, Grune & Stratton. 1946. $12.00.

In the past three years, since the first edition of this book was published, a tremendous amount of new literature on allergy has appeared in the medical press. It has become increasingly evident that an understanding of allergic disease is necessary to the adequate practice of general and specialized medicine.

These newer findings have been added to the already very complete presentation which characterized the first edition. Fields now in the process of discovery and study, such as psychosomatic aspects of allergy, Rh factors in allergy, allergic aspects of rheumatic fever, periarteritis nodosa and lupus erythematosus are included, as well as the newer technics and concepts in therapy.

The format has been revised and the resulting narrower column is easier to read. This edition is recommended as an up to date, improved reference and text book for all students of allergy.

LOUISE FISHER, M.D.

COUNTY SOCIETY REPORTS

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* held at Bergen Pines Hospital, Oradell, on March 11, was called to order by the president DR. ALBERT W. CLOUD, at 9:08 p. m.

The following applicants were elected to full membership: Doctors Alfred A. Alessi, Teaneck (by transfer from Medical Society of County of New York); Samuel F. Bassett, Dumont; Eugene J. Audi, Glen Rock. Doctors James R. Scheip, Oradell, and Liborio N. Spitaleri, Lodi, were elected to associate membership. Dr. Michael L. Lewin, Tenafly, was elected to courtesy membership.

The speaker of the evening, DR. ARTHUR W. GRACE, Professor of Clinical Dermatology and Syphilology, Long Island College of Medicine, was introduced by Dr. Rudolph C. Schretzmann. *The Treatment of Syphilis with Emphasis on the More Modern Concepts* was Dr. Grace's topic and he pointed out the existence of two new schools of therapy, the older school built around salvarsan and the newer school using penicillin. Both of these schools are tested with fever therapy as an adjunct. Several electrophotomicrographs of the spirocheta pallida were shown. After the historical review of the treatment of lues, dating from Ehrlich, in 1910, Dr. Grace demonstrated the dangers of rapid mapharsen therapy and the ineffectiveness of fever therapy alone in early syphilis.

The president presented DR. SAMUEL ALEXANDER, Past President of The Medical Society of New Jersey, and a member of the Bergen County Board of Chosen Freeholders, who explained the details of the Bergen County Hospital Plan. Following his exposition with keen interest, a great number of questions were asked of Dr. Alexander, bringing out a number of opposing views, with the result that DR. CHARLES BLEASBY, also a member of the Bergen County Board of Chosen Freeholders, requested permission to address the Society at the next regular meeting.

BURLINGTON COUNTY

T. B. Dickson, Reporter

On March 13, the *Burlington County Medical Society* meeting was held at the Riverton Country Club.

The speaker of the evening was DR. HARRY TWINING of Hahnemann Hospital, Philadelphia, Pa. He spoke to the Society on practical tips on diagnosis and treatment of common skin disorders. Dr. Twining discussed all the common skin diseases. The talk was a complete review of these conditions and refreshed the memory of every member present.

Dr. Leonard was approved to direct the Burlington Keep-Well Baby Clinic.

A Medical Telephone Exchange is being started in Burlington. Anyone in the County Society interested in this service should contact the secretary. It is possible that out-lying stations may be established to cover all the county.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

Camden County Medical Society held its monthly meeting on March 4, at the Staff Room of the Cooper Hospital, DR. HENRY DECKER, president, presiding. The scientific program consisted of the presentation of cases by members of the Cooper Hospital staff.

Miss Anderson of the Metropolitan Life Insurance Company, explained to the Society their nursing service for their policy holders. All cases must be referred to them by the family physician and written orders only will be carried out.

Members introduced to the Society were: Dr. Albert E. Kay, Dr. Nicholas R. Musulin, Dr. H. Edward Yaskin, Dr. Hammell P. Shipps.

DR. J. WESLEY JACK, chairman of the Welfare Committee, spoke on *The Licensing and Training of Practical Nurses* the discussion of which will be taken up by the Board of Trustees of The Medical Society of New Jersey.

The newly-elected members to the Society were Dr. Eugene H. Dekampis and Dr. Louis G. McAfoos, Jr.

Dr. Ralph Hollinshed took charge of the scientific program. The first paper was *Influenza Meningitis in an Infant* by DR. VINCENT DEL DUCA.

Care of Aplastic Anemia by DR. WALTER CRIST was the second paper. Slides were shown by Dr. Reed.

The third presentation was by DR. PAUL MECRAY, JR., on first, *Multiple Polyps of the Colon* showing the condition of two patients five years after operation; and second, *Carcinoma of the Rectum* showing the advantage of two surgical teams operating at the same time. Slides demonstrated the necessity of different approaches for the removal of carcinoma of the rectum. Dr. Mecray, Jr., stressed that the operation should fit the patient.

ESSEX COUNTY

Asher Yaguda, M.D., Reporter

The annual meeting of the *Essex County Medical Society* was held Thursday, May 8, at the Academy of Medicine of Northern New Jersey, Newark, with the president, DR. THOMAS W. HARVEY, presiding.

Dr. Harvey in his final presidential address, traced the history of the Essex County Medical Society from its inception in 1816 with eleven members, to the present with a membership of 1478. An interesting feature of the paper was a series of lantern slides showing the medical fees established by the Society in 1816. The fees ranged from 25 cents for house calls and $3.00 for the delivery of a baby, to the most expensive operation which cost $50.00. Dr. Harvey was presented with the president's key by DR. HARROLD A. MURRAY, the new president of the Society.

Dr. Murray in assuming the presidency for the coming year outlined his program which will be devoted to efforts to insure that "every individual

in the county receives adequate medical care". Dr. Murray plans an intensive program of public health education and activity which will stress integration of the efforts of the Medical Society with civic organizations and existing health agencies.

The following officers were elected to serve for the coming year: President-Elect, Dr. George Blackburne; First Vice-President, Dr. J. I. Echikson; Second Vice-President, Dr. O. G. Matheke; Secretary, Dr. M. H. Greifinger; Treasurer, Dr. R. H. Rogers; Reporter, Dr. Asher Yaguda; Councilors for two years, Dr. N. A. Antonius and Dr. A. J. Ganley; Delegate to the State Nominating Committee for 1948, Dr. H. R. Van Ness. Twenty-seven delegates to the State Society were also elected.

GLOUCESTER COUNTY

Louis K. Collins, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, May 15, with the president, Dr. Louis K. Collins, presiding.

Dr. Wendell Burkett gave an extensive report for the Legislative Committee revealing the status of the several New Jersey and Congressional bills affecting the medical profession. Dr. William Harris of the Public Health Committee then reported on the proposed blood donor service for Gloucester County which the Red Cross hopes to inaugurate in the near future. It was decided to leave the matter in the hands of the Committee for approval or disapproval, so that the matter would not have to be tabled over the summer.

Dr. William Harris then presented an interesting case report, after which Dr. Ralph Moore discussed histamine cephalgia. A motion picture showing the use of oxycel in Caesarean section was viewed through the courtesy of Parke, Davis and Co.

The following officers were elected for the coming year:

President, Dr. Joseph Hughes, Woodbury; Vice-President, Dr. Fred Faux, Woodbury; Secretary, Dr. Clarence Bowersox, Woodbury; Treasurer, Dr. David Brewer, Jr., Woodbury; Historian, Dr. Dorothy Rogers, Woodbury; Reporter, Dr. Louis Collins, Glassboro; Trustee for 3 years, Dr. Wendell Burkett, Pitman; Censor for 3 years, Dr. Frederick Wandall, Clayton; Delegate to State Society for 3 years, Dr. Baxter Livengood, Woodbury; Alternate delegate for 3 years, Dr. Clarence Bowersox, Woodbury; Member of Nominating Committee, Dr. Livengood; Alternate, Dr. Wendell Burkett, Pitman.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting on April 1, at the Masonic Club in Jersey City. Dr. C. E. McNenney presided.

Dr. Jaffin called the attention of the meeting to the fact that April has been designated "Early Diagnosis Month" for tuberculosis, and urged the physicians of the county to avail themselves of county diagnostic clinics when their patients cannot afford private facilities.

The following members were nominated to serve as the Nominating Committee in 1948: Drs. Evans, Botti, Kiely, Brennock and Sager.

The following applicants were elected to membership: Doctors Bernard D. Rubin of Bayonne, Bernard D. Abers, Marshall Bergen, Leo Levitov, Herman Litwer and Phillip Russillo of Jersey City; Maurice Kamp of Union City; and Eli Starr of West New York. Dr. Morris Green of West New York, and Dr. A. M. Milanesi of North Bergen were reinstated.

On the Scientific Program, Dr. Coleman B. Rabin, Associate in Medicine at Columbia University and at Mt. Sinai Hospital, was the guest speaker, taking as his subject "Thoracic Complications in the Postoperative Period". Dr. Rabin discussed several infections to which the lungs may be susceptible in the postoperative state, emphasizing the importance of a proper choice of anesthetic. Among the complications discussed were postoperative pneumonia, putrid abscess of the lung, subphrenic abscess, pulmonary edema and pulmonary embolism. Discussants were Drs. Gleason, Jaffin, Potter and Thomas White.

HUNTERDON COUNTY

Philip W. Baker, M.D., Secretary

The *Hunterdon County Medical Society* held a dinner meeting on Tuesday evening, April 29, at the new Doric House in Flemington.

A scientific session preceded the business meeting, with a very interesting and practical illustrated talk by Dr. George Sommer, Jr., of Trenton. His topic was "The Diagnosis and Treatment of Suppurative Diseases of the Bronchi and Lungs". He especially emphasized the importance of accurate diagnostic procedure for the proper approach to the treatment of bronchiectasis. An enthusiastic discussion followed this enlightening speech, thus answering many problems of the general practitioner.

The business meeting was called to order by Dr. Baker, the retiring President. Dr. Barclay Fuhrmann made a few remarks concerning the chiropractic bills that have recently come before the State Legislature. He also reported on the present clinical set-up for cancer control in Hunterdon County.

The annual election of officers followed with these results: President, R. J. Germain; President-Elect, Edwin Merrill; Vice-President, John Fuhrmann; Secretary, Philip Baker; Treasurer, Barclay Fuhrmann; Delegate to the State Society, A. M. Jenkins; Alternate, Wm. Galeota; Member of State Nominating Committee, Barclay Fuhrmann; Alternate, S. B. English.

Dr. Germain, the new President, promptly made the following appointments: Board of Censors, Doctors Fritz, Lane and Boyer; Reporter, Dr. Baker; Executive Officer, Dr. Barclay Fuhrmann.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The Monmouth Memorial Hospital was again host to the *Monmouth County Medical Society* at its regular monthly meeting on April 30. The scientific session began with the showing of a moving picture entitled "Introgastric Drip Therapy for Peptic Ulcer". The etiology of peptic ulcer was discussed with special emphasis on the predisposing factors. The technic of the drip therapy was illustrated and discussed. Finally evidence of its effectiveness were presented.

DR. STANLEY NICHOLS, Chairman of the Public Health Committee, presented a paper on the public health responsibilities of practicing physicians. He discussed just what public health is and what it means to us as medical men. Dr. Nichols ended his paper reminding us all to be medical statesmen rather than medical politicians.

Dr. Nichols introduced the next speaker, DR DANIEL BERGSMA, Deputy Director of the State Department of Health. The subject of Dr. Bergsma's paper was the relationship of State Department of Health to the practicing physician. The various branches of the Department of Health were enumerated; their respective work and interrelation were discussed. Dr. Bergsma reminded us of the facilities of the Department of Health that are available to the practicing physician. Also outlined were the responsibilities of the physician to the Department of Health and through this to the public. The most important of these are as follows:

1. Accurate diagnosis and the obtaining of consultations when necessary early in the course of disease.
2. Early and effective treatment to eliminate mortality and morbidity.
3. Preventive medicine—to search out other problems and to care for them.
4. Consideration of the age, sex, race and employment of patients.
5. Aid in the education of the public in public health measures.
6. Routine reports of deaths, births and disease promptly.
7. Obtain free care for those in need of it.

DR. ROSCOE KANDLE, Director of the Division of Preventable Disease, State Department of Health, was the last speaker. Dr. Kandle's paper was on the use of penicillin in venereal disease. Several important factors were emphasized in the use of penicillin.

Dr. Blaisdell closed the scientific program with a few short sentences emphasizing the responsibility of medical men and the need of their cooperation in programs to prevent disease.

The business meeting was opened with a report of the executive committee. The voting on the adoption of the amendment to the constitution was postponed because of the attendance.

The Executive Committee reported that it had passed on the application of Mr. Vincent Gorman for the position of Executive Secretary to take effect June 1, 1947. A motion was made to accept Mr. Gorman's application. The motion was passed.

Dr. George Bruzza, Sea Girt; Dr. John Tilly, Keyport, and Dr. Richard Dusbery, Marlboro, were elected to associate membership. Dr. Martin Rush of Red Bank was admitted to full membership.

MORRIS COUNTY

John S. Forbes, M.D., Reporter

Regular monthly meeting of the *Morris County Medical Society* was held in Morristown on April 17. The president, DR. ALDEN KING, presided over a short business meeting and then DR. I. F. FROST presented the guest speaker, the visiting surgeon at Harvard University Hospital, and head of the circulatory clinic at Massachusetts General Hospital, DR. ROBERT R. LINTON who spoke on *Pulmonary Embolism*. Among the factors associated with embolism, Dr. Linton listed old age, fractures, inadequate postoperative care, delay in diagnosis and major surgical procedures generally.

Dr. Linton listed three prime indications for bilateral femoral vein ligation. These were: (a) pain and tenderness in the calf, (b) major surgery in patients more than 50 years old, and (c) a positive Homan sign, which is defined as dorsiflexion of the foot to produce stretching of gastrocnemius muscle. The speaker also reviewed the use of anticoagulants as a prophylactic rather than a therapeutic device.

Following the formal talk, the essayist presented colored moving picture films outlining the technic of bilateral femoral vein ligation with extraction of the clot.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday, March 18, at the Administration Building, Paterson, with DR. HARRY WOLFSON, our president, presiding.

The following applicants were elected to active membership: Doctors Archie K. Ged, Michael W. Silver, Saul J. Pearlman, Gustav Friedman of Paterson, and J. Lloyd Morrow of Passaic. Dr. Michael L. Lewin of Paterson was elected to courtesy membership. Doctors Alvin H. Krakower of Paterson, and Robert F. Ficker of Erskine Lakes, Wanaque, were elected to associate membership.

The following resolution on the death of DR. ALBERT H. WARD was unanimously adopted:

Dr. Albert H. Ward, aged sixty-seven, of 404 Totowa avenue, Paterson, New Jersey, left this mortal life February 10, 1947.

Dr. Ward, who was born in Paterson, the son of Martin Luther and Julia Scott Ward, received his early education in the local schools; his medical education at the Columbia University College of Physicians and Surgeons in New York City.

He began his medical practice in Paterson in 1905, and continued until 1940 when illness forced him to retire. On the Staff of Saint Joseph's Hospital, Paterson, New Jersey, from 1907 to 1940—he acted as Associate Physician, and later as Attending Physician to the Medical Department.

Having a distinguished war record, Doctor Ward was a veteran of the First World War. He served in France with the Second Division; was wounded

in the Argonne Forest and was awarded the Purple Heart.

The following resolutions are offered:

WHEREAS: The Almighty God in His Infinite Wisdom, has deemed it best to take from our midst, Albert H. Ward, the quiet, unassuming and devoted physician; faithful friend and respected citizen, and

WHEREAS: the Officers and Members of the Passaic County Medical Society feel that the loss of so fine a resident and colleague will be felt keenly by all with whom he came in contact through many years of service and a well spent life, and

WHEREAS: His departure marks a severe loss to his family, to our community, and to those with whom he was associated in his professional and private life, be it therefore

RESOLVED: That the Passaic County Medical Society extend to the bereaved family of its late friend, Albert H. Ward, its heartfelt sympathy, and

BE IT FURTHER RESOLVED: That we express the hope that the memory of his sterling character and the services he rendered will serve as a source of consolement to them in their period of bereavement and,

BE IT FURTHER RESOLVED: These these Resolutions be spread in full on the minutes, and a copy delivered to the family of the deceased.

Dr. Homer H. Cherry, of Valley View Sanatorium, presented a plan for chest x-rays to be carried and worked out by the hospitals, which was approved.

Dr. Wolfson introduced the speaker of the scientific session, GORDON PALMER MCNEER, M.D., member of the National Gastroenterological Association, American Radium Society and Fellow of the American College of Surgeons. Dr. McNeer spoke on the *End Results in Treatment of Cancer of the Stomach* and illustrated his talk with lantern slides.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The regular meeting of the *Warren County Medical Society* was held at Morries Acres on April 16, with the President, DR. PHILIP KASSOW, presiding.

The new By-Laws which were read at the previous meeting were approved as read, and Dr. H. B. Bossard, Chairman of the By-Laws Committee, was instructed to have 100 copies printed. It was moved, seconded and carried that each member and all new members be assessed $1 for a copy of the By-Laws.

Dr. E. Martin of Belvidere, and Dr. S. Szittya of Phillipsburg, whose names were presented at the last meeting, were elected to membership.

DR. WILLIAM SKINNER and DR. LEON FRIEDMAN of Easton, Penna., were elected visiting members of the Society.

Dr. William Varney, the secretary, read a communication from Dr. Yorke about the Veterans Administration, also a communication from the Warren County Chapter of the National Foundation for Infantile Paralysis. Dr. A. Zuck of Washington, and Dr. Paul Drake of Phillipsburg were elected members of the Advisory Committee for same.

The committee appointed at the last meeting to confer with Warren Hospital about setting up an isolation ward at the Hospital reported that the ward would be open in the very near future.

The Society approved the American Red Cross Blood Donor System set up by the Phillipsburg Chapter. The Chapter will maintain a list of donors, their addresses, and blood types in order that blood of any type may be obtained on short notice. Under the plan, the Chapter provides free transportation of donors to and from the hospital. The system is regarded as the first step toward eventual creation of a blood bank in Phillipsburg by the Red Cross.

The Society went on record as opposed to a bill in the State Legislature which would permit veterans who graduated from other than Class A Medical Schools to take the State Board examinations. Opinion of the Society was that the academic standards of doctors must be maintained to insure fully qualified practitioners.

DR. WILLIAM SKINNER of Easton read a paper on aneurysm of the heart and showed x-ray plates of a case.

The meeting adjourned to the dining room where a turkey dinner was served to the members of the Society and the Woman's Auxiliary. Mrs. Frederick Wandall, President of the State Auxiliary, met with the ladies, and at the dinner gave a very pleasing address. She was accompanied by Dr. Wandall who attended the medical meeting.

NEW JERSEY OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Benjamin Daversa, M.D., Secretary, Spring Lake

A *New Jersey Obstetrical and Gynecological Society* was organized by 125 members of The Medical Society of New Jersey at its 181st Annual Meeting at Haddon Hall, Atlantic City, on April 23, 1947.

After adopting a constitution and by-laws, the new organization elected the following officers: DR. SAMUEL COSGROVE, of Jersey City, president; DR. HERSCHEL S. MURPHY, of Roselle, President-elect; DR. GEORGE GERMAN, of Camden, vice-president; DR. BENJAMIN DAVERSA, of Spring Lake, secretary; DR. OSBORNE CHRISTIANSEN, of Hackensack, treasurer, and the following members of the executive council; Dr. Daniel Geary, of Morristown and Dr. John Preece, of Trenton, for one-year terms; Dr. Raymond Potter, of East Orange, and Dr. Harrison B. Wilson, of Hackensack, for two-year terms; Dr. Samuel Berkow, of Perth Amboy and Dr. Carlisle Brown of Atlantic City, for three-year terms, and Dr. Frederick Fahrenbruck, of Mount Holly, and Dr. Robert MacKenzie, of Asbury Park, for four-year terms.

Our aims as outlined in the constitution include maintaining high standards of obstetric and gynecologic practice and to aid in the scientific advancement of its members.

The society is tentatively scheduled to hold its second meeting in Jersey City in October, 1947.

WOMAN'S AUXILIARY

MEMORANDA FOR PRESIDENTS OF COUNTY AUXILIARIES

Mrs. Lodovico Mancusi-Ungaro, President

1. It is recommended that a meeting be called of the treasurer, the membership chairman, and the yearbook chairman, to clarify all records—paying particular attention to spelling, addresses and zoning. It is planned to have an addressograph plate made for each Auxiliary member this summer, so the importance of immediate cooperation is understood.

2. It is important that each county president in cooperation with the members of her Executive Board assist the chairman of public relations to draw up a list of key women in the county, giving their full names, addresses and the field in which they are outstanding. This list should be sent immediately to the state chairman of public relations, Mrs. Asher Yaguda, 61 Lincoln Park, Newark 2, New Jersey. A copy should be kept by the county chairman of public relations.

3. If a list of the incoming officers and committee chairmen, together with their names and addresses and the positions they occupy in the County Auxiliary, has not been sent to your president, it should be forwarded immediately to her.

4. Each county president is requested to appoint subject matter chairmen to correspond with the committees of the State Auxiliary: i. e., Bulletin, Hygeia, Legislation, Press and Publicity (with a subchairman of clippings), Medical History, Public Relations (with a subchairman of health), Postwar Planning and Safety and a chairman for Widows and Orphans.

5. If it is the custom of your Auxiliary to invite the State President on a certain day of a certain month, it would be of help to her to inform her now. The President-Elect, Mrs. Robert B. Walker, 29 S. Adelaide Avenue, Highland Park, should also be included in all invitations to your President.

6. June 16th has been selected for a public relations program on a state level, and should be watched with interest by all Auxiliary members.

7. Save June 23rd for Mrs. Walker, your President-elect and your Conference chairman, for the workshop in Trenton.

AUXILIARY CONFERENCE WORKSHOP

JUNE 23, 1947

The first Conference Workshop of the Woman's Auxiliary to The Medical Society of New Jersey will be held in the Executive Offices of The Medical Society of New Jersey, 315 West State Street, Trenton, at 10:30 a. m., Monday, June 23, 1947. Each County subject matter committee chairman will meet with the State chairman of both the Auxiliary and The Medical Society around an informal round table. The problems of each committee will be discussed individually, the method of handling the procedures of each committee for the coming year evolved, and the scope and the aims of the Auxiliary clarified.

Each County Auxiliary President is urged to see that her chairmen of Hygeia, Legislation, Program, Public Relations with its subcommittee chairmen of Health, Postwar Planning and Safety, Press and Publicity and its subcommittee chairman of Clippings, and the chairman of Widows and Orphans attend.

AUXILIARY CONVENTION REPORT

The 20th Annual Convention of the Woman's Auxiliary to The Medical Society of New Jersey was held at Haddon Hall, Atlantic City, April 22, 23 and 24, 1947.

On April 22, Mrs. Frederick G. Wandall of Clayton, President, was hostess at luncheon to the entire Executive Board. Following the luncheon a pre-convention Board meeting was held and at 3:30 p. m. an informal get-together and tea for all physicians' wives, was enjoyed. In the evening the Fellowettes held their annual dinner. Mrs. William E. Dodd of Beach

Haven was chairman. At this dinner, Mrs. Wandall was installed as a Fellowette.

On April 23 the general session opened with an Invocation by Rev. Arthur J. Blythe, Rector of St. James Episcopal Church, Atlantic City. Mrs. Charles Hyman, President of the Woman's Auxiliary to the Atlantic County Medical Society, extended to the Convention a friendly welcome to Atlantic City and Mrs. Lodovico Mancusi-Ungaro, President-Elect, in response said that the hospitality of Atlantic County is always gracious and each year the members joyously return to accept their hospitality.

Mrs. Oswald Carlander, Fellowette, conducted an impressive memorial service for departed members.

Dr. William E. Dodd of Beach Haven, Chairman of the Advisory Committee to the Woman's Auxiliary for The Medical Society of New Jersey, spoke briefly. He said that it is easy during war years to carry on the work, but when the war is over there is a tendency to let down. However, with the Woman's Auxiliary it has not been so, as they have gone forward to greater accomplishments. He thanked the organization in behalf of the Medical Society and stated that the ladies have inspired the doctors to do better work.

Two special guests, Mrs. George C. McElfatric of Wilmington, President of the Woman's Auxiliary to the Medical Society of Delaware and Mrs. H. F. Pohlmann of Middletown, President of the Woman's Auxiliary to the Medical Society of New York, were introduced. Each expressed their pleasure in attending the convention and their gratitude to the members for the gracious hospitality accorded to them.

Following the morning session a luncheon was given honoring the retiring President, Mrs. Wandall, for her supreme efforts in behalf of the Auxiliary.

Mrs. A. Haines Lippincott, of Camden, senior Past President, was Toastmistress and very effectively introduced each member at the guest table. Dr. Frank Scammell, President of The Medical Society of New Jersey, greeted the members and spoke on the training of children.

Dr. Frank F. Borzell, Vice-Speaker, House of Delegates, American Medical Association, in addressing the guests, warned of attempts to introduce communistic trends into the medical profession and declared that the profession is compelled to work against legislation which would place the doctors on a basis of regimented employees. He said that the communistic threat emphasizes the financial basis rather than the important issues of health, education and good living. The doctors of America have not been mercenary, but have given liberally of their time to those unable to afford paying.

Mrs. Lippincott presented Mrs. Wandall with the President's pin and spoke in glowing terms of the splendid work she has done during her term of office.

The business session reconvened at 3:00 p. m. and the election and installation of officers took place. Mrs. Ralph J. Faulkingham of New Brunswick offered resolutions, which were entered in the minutes, thanking Mrs. David B. Allman and her chairmen for their achievement in making the convention a complete success, the Atlantic County Auxiliary for their gracious hospitality and the manager and personnel of Haddon Hall for their courtesies.

On April 24, Mrs. Mancusi-Ungaro of Newark, newly elected President, entertained at breakfast for the outgoing Executive Board of the Woman's Auxiliary and for those who will serve the new administration. Dr. Royal A. Schaaf of Newark, newly elected President of The Medical Society of New Jersey, and Dr. William Dodd of Beach Haven were guests of honor. Mr. Arthur Conrad, a prominent Chicago Attorney and a doctor of Jurisprudence, was guest speaker. He emphasized the spread of socialism and stated that the doctors have been set apart for the opening wedge for socialism, through socialized medicine. He said that the infiltration of communism in our country is pronounced and declared that it is being so cleverly done, that even in the books our children use in school there are communistic lines intended to inculcate communism in the young minds.

Following the breakfast a post convention Board meeting was held, at which time Mrs. Mancusi-Ungaro outlined her program for the year.

COUNTY AUXILIARIES

Atlantic County

Mrs. Samuel L. Salasin,
Chairman, Press and Publicity

The *Woman's Auxiliary to The Medical Society of Atlantic County* heard Dr. S. William Kalb and Dr. David B. Allman as speakers at the Health Education Day program sponsored by the public relations committee with Mrs. David B. Allman as chairman and Mrs. D. C. Reyner co-chairman, on February 14, in the Rose Room, Traymore Hotel.

Mrs. Charles Hyman, President of the Auxiliary, welcomed the members and guests. Mrs. Frederick G. Wandall, President of the Woman's Auxiliary to The Medical Society of New Jersey, brought greetings and told briefly of the work that is carried on by the Auxiliary members in helping on health education programs such as cancer control, tuberculosis, national heart week. Mrs. David B. Allman presented the speaker for the Health Education program, Dr. S. William Kalb, Nutrition Committee Chairman of the State Medical Society. He spoke on "Nutrition in Medical and Public Education."

Following Dr. Kalb's talk, Dr. David B. Allman, well known local surgeon, spoke on "The Fears, Fads and Fact on Infantile Paralysis".

Mrs. Charles Hyman conducted a short business session at which time, Mrs. Robert A. Bradley, chairman of the nominating committee, presented the following nominations for 1947-1948: President, Mrs. Edward H. Dyer; President-Elect, Mrs. William O. Roop; First Vice-President, Mrs. Harry Subin; Second Vice-President, Mrs. Louis Rosenberg; Treasurer, Mrs. Raymond A. Williams, and Recording Secretary, Mrs. Max Gross.

Camden County

Mrs. Wilmer F. Burns,
Chairman, Press and Publicity

The Twentieth Annual Health Institute of *The Woman's Auxiliary to The Camden County Medical Society* was held March 25, at the Camden Woman's Club.

The program entitled *Health Challenges of Today,* was arranged by Mrs. Henry R. Tatem. Greetings were extended to the group by the President, Mrs. A. Lincoln Sherk; by Mrs. Frederick G. Wandall, President of the Auxiliary to The Medical Society of New Jersey; and by Dr. Henry B. Decker, President of the Camden County Medical Society.

Helen F. Schrack, M.D., discussed *The Ideal Health Program for School Children.* Dr. Schrack said children must be taught the elements of personal hygiene; the necessity of routine dental examinations; good posture; proper diet; preventive medicine; social hygiene; and mental and emotional health.

Dr. William G. Leaman, Professor of Medicine at The Woman's Medical College of Pennsylvania, speaking on *The Challenge of Rheumatic Fever,* declared the Nation's wealth depends on the health of our children and many are stricken. He deplored the lack of financial support given for research on this disease.

A third speaker, Edward J. Tallant, M.D., of Jefferson Hospital, gave an illustrated lecture on *The Newer Drugs.*

A film entitled *Time Is Life* was shown through the efforts of Mrs. Arthur J. Casselman.

After the program Mrs. Penrose Thompson and her committee served tea to the one hundred and twenty-five people present who represented all organizations in Camden County.

Essex County

Mrs. Ames L. Filippone,
Chairman, Press and Publicity

The March meeting of the *Woman's Auxiliary to the Essex County Medical Society* was designated as President's Day. Mrs. Samuel Jessurun, chairman of the day, arranged a very elaborate program for this occasion. As Mrs. Jessurun unveiled each portrait, Mrs. Roy Van Ness gave a detailed biographical sketch of each president. The pictures hang in the Eagleton Civic House along with one of the late Dr. Wells P. Eagleton, presented in his memory by his wife, and another of Mrs. Eagleton. Mrs. Frank S. Forte presided at the business meeting directly preceding the program. Dr. Joseph Echikson, president of the Academy of Medicine of Northern New Jersey, congratulated the members and accepted the custody of the pictures in behalf of the Academy of Medicine. He urged that members continue their efforts in serving the community, especially during the Cancer Drive.

The pictures were unveiled in the order the presidents served, and were as follows: Mrs. George Rogers, Mrs. H. Roy Van Ness, Mrs. Theodore Teimer, Mrs. F. J. McCauley, Mrs. Don Epler, Mrs. K. G. Forsyth, Mrs. Frederick Shaul, Mrs. Charles Rathgeber, Mrs. Gustave Braun, Mrs. William D. Miningham, Mrs. J. Irving Fort, Mrs. Edward W. Sprague, Mrs. Asher Yaguda, Mrs. Harry Comando, Mrs. Lodovico Mancusi-Ungaro, Mrs. S. Bernard Kaplan and Mrs. Frank S. Forte. Each president received a beautiful corsage. A social hour followed with Mrs. George Rogers and Mrs. Frank S. Forte pouring at the tea table.

On April 2, 1947, the Auxiliary sponsored a very remarkable and highly publicized All Day Institute: *Women in Health and Action.*

Mrs. Frederick J. Wandall, president of the Woman's Auxiliary to The Medical Society of New Jersey, was on hand to greet the assembly. Mrs. S. Bernard Kaplan was general chairman of the program and Dr. Rita S. Finkler, endocrinologist, was moderator of the panel discussion. Each phase of life from infancy to old age was discussed from the physical, mental and social aspect by prominent women physicians of New Jersey, each a specialist in her respective field: "Birth to Adolescence" by Dr. Mildred Gregory and Dr. Anna Levy; "Adolescence to Marriage" by Dr. Margaret M. Wurts and Dr. Zelda Marks; "Marriage and Motherhood" by Dr. Elisabeth Ward; "Menopause and Approach to Old Age" by Dr. Rita Finkler.

Mrs. Frank S. Forte extended a very cordial welcome to all present. Those who attended will long remember the day as "tops" in programs of true educational value. Mrs. S. Bernard Kaplan, whose untiring efforts made this program possible, has earned the endless praise and sincere gratitude of the Auxiliary.

Gloucester County

Mrs. Joseph F. Hughes,
Chairman, Press and Publicity

The Woman's Auxiliary to the Gloucester County Medical Society held their monthly business meeting at the home of Mrs. A. Guy Campo, Westville.

on February 20, at which time philanthropic projects were discussed. It was decided to donate a ceiling projector and microfilm library to Tilton General Hospital, Fort Dix. Plans are being made to hold a series of benefit card partles throughout the county to finance the project.

Hudson County

Mrs. Sydney Chayes,
Chairman, Press and Publicity

Mrs. Edward Murphy, president, presided at the regular monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* held at the Young Women's Christian Association, Jersey City, on Monday, April 7.

Mrs. William Harz of Bayonne was introduced and welcomed as a new member.

An election of officers was held, the installation to be at the May meeting. Mrs. Louis Perkel was named to the presidency with Mrs. Sydney Chayes president-elect; Mrs. William Gleason, first vice-president; Mrs. Francisco Figerelli, second vice-president; Mrs. Benjamin Macchia, recording secretary; Mrs. Oscar Jacks, corresponding secretary, and Mrs. Harry Perlberg, treasurer.

Delegates chosen to represent the auxiliary at the Annual State Meeting in Atlantic City are Mrs. John Madaras, Mrs. Joseph Murray of Bayonne, and Mrs. Louis Perkel and Mrs. Francis Figuerelli from Jersey City.

The play day luncheon and bridge will be May 27, at the Montclair Athletic Club with Mrs. Arthur Largay and Mrs. Carl Tannert in charge. Proceeds of this party will be donated to the cancer campaign and to the Red Cross for recreational facilities at Halloran Hospital.

Tea was served after the meeting, with Mrs. Arthur Largay pouring.

Mercer County

Mrs. Joseph R. Burns,
Chairman, Press and Publicity

Mrs. Ernest F. Purcell, president, welcomed over one hundred people to the Public Relations meeting and Tea sponsored by the *Woman's Auxiliary to the Mercer County Medical Society* on Monday afternoon, April 14, at the State Society Headquarters.

Among the women's organizations throughout Mercer County represented were the Women's League of Voters, Rider College medical secretary students, College Club of Trenton, Cancer Control Society, Contemporary Club, Glen Afton Civic Association, Blessed Sacrament and various other Parent Teacher Associations, Yardley W.C.T.U., St. Francis Aid, Mercer Hospital Women's Aid, McKinley Women's Aid, American Friends Service and the Columbus Branch Family Service.

The topic of discussion was "Mental Health". Mrs. C. Chester Chianese, Program Chairman of the Auxiliary, presented the speakers. An introductory address was given by Mrs. Frederick J. Wandall, President of the State Auxiliary; following, was a very interesting talk by Mrs. Katherine S. Perault, Educational Director of the New Jersey State Hospital. Her subject covered the teaching of the psychiatric technicians of the hospital and the objectives of the hospital in relation to teaching the public.

Dr. Henry A. Cotton, Chairman of Health and Hospital Divisions of the Council of Social Agencies in Trenton, was the main speaker of the meeting. His subject *Mental Diseases* was illustrated with motion pictures.

Mrs. George N. J. Sommer, Public Relations Committee Chairman, was hostess at the Tea following the meeting.

Middlesex County

Mrs. Norman Rosenberg,
Chairman, Press and Publicity

The February meeting of the *Woman's Auxiliary to Middlesex County Medical Society* was held on Wednesday evening, February 19, 1947, at 8:30 p. m., at the home of Mrs. Zoltan Lind, 215 Livingston Avenue, New Brunswick, N. J. Mrs. R. B. Walker opened the meeting and called the various chairmen for their reports. Mrs. Jacobson reported she had obtained twelve new subscriptions to the *Bulletin* and Mrs. Nathan Karshmer announced there were seventeen new members so far this year. Mrs. F. M. Hoffman, chairman of Ways and Means exhibited a beautiful afghan which she had made and for which chances are to be sold. It will be raffled off in the spring. A motion was made and seconded to give two subscriptions of *Hygeia* to the schools. Mrs. M. S. Brody, under new business brought up as a permanent project for our group the subsidizing of research work now going on at St. Peter's Hospital. This idea met with general approval, but must first be submitted to our advisory board. In the meantime, it was decided to hold the next meeting at the home of Mrs. Brody on March 19. Mrs. Zoltan Lind and Mrs. William Stein were chosen chairmen of the annual luncheon which is to be held on May 21, at Oak Hills Manor, Metuchen. A penny sale then followed the adjournment of the business meeting. Delicious refreshments closed the evening's enjoyment.

Monmouth County

Mrs. Joseph E. Bossone
Chairman, Press and Publicity

The *Woman's Auxiliary to the Monmouth County Medical Society* held its monthly luncheon meeting on February 18 at Freehold. Mrs. George McDonnald acted as hostess. Mrs. Norman Nathanson, president, presided.

Mrs. Jack Levin was presented with a corsage in recognition of her outstanding work in obtaining blood donors for the Monmouth county blood banks. Mrs. Joseph E. Bossone, Mrs. Leo Rocco, and Mrs. Stephen Casagrande also received awards for their efforts towards maintaining the blood banks in Monmouth County.

Plans were made for the Auxillary to give a dinner dance for the Monmouth County Medical Society and their wives on March 29, at the Berkeley Carteret Hotel in Asbury Park. Mrs. Stephen Casagrande is chairman. Mrs. Joseph E. Bossone, Mrs. Anthony Perrotto and Mrs. Leo Rocco will assist Mrs. Casagrande.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **June, 1947** **No. 6**

IT IS often overlooked that the ultimate control of tuberculosis will depend upon the effectiveness of the training given to the infected individual. Case finding in tuberculosis is of little value unless it is followed by treatment; to go to a sanatorium is not as important as to remain there until the disease is arrested; the permanence of the arrest in any case of tuberculosis is always a matter of personal discipline and vigilance. At every step of the road the physician must keep the conscious active cooperation of the patient. This comes about only when continuous education of the patient is carried on by the physician and those associated with him.

THE CARE AND EDUCATION OF THE TUBERCULOUS PATIENT IN THE HOSPITAL

The care of a patient in any institution is dependent upon the physical facilities of the hospital or sanatorium; the proper balance of staff; and the quality of the staff. An adequate budget is necessary but money is not the entire answer. A well-equipped sanatorium may still be a cold, unsympathetic place. There must be an *esprit de corps* that starts at the top and carries through to every worker in the place.

The importance of a proper balance of staff is self-apparent. There must be enough physicians, enough nurses, a satisfactory dietetic service, enough social workers, enough rehabilitation workers, and enough accessory attendants to carry on the work properly.

The quality of the staff will depend upon the training, the experience and the personal interest of every person who takes part. Adequate salaries are necessary to attract and hold competent personnel.

Preemployment training and experience are desirable, and training should be continued throughout the period of employment. There should be frequent and regular staff conferences, not for the physician alone, but for the entire administrative group, the nurses, social workers, and rehabilitation workers. Not only medical and surgical treatment, but problems of discipline, emotional instability and psychological approaches should be discussed. The staff should all learn to think as a unit. As a result, when a physician advises a patient and the patient asks the same question of the nurse or the social worker, there will be agreement among them. Some may feel that only a doctor should discuss medical subjects, and that nurses, social workers, and others should always refer such questions to the doctor. That is true if the answers are difficult but no doctor ever loses prestige when his staff gives him informed backing and support.

In the treatment of tuberculosis the work of the doctor, the nurse, the social worker, and the rehabilitation worker so dovetail that they are frequently helping with the same thing. All four "practice medicine" in some way, whether it be in treatment, care, or maintaining the proper mental equilibrium of the patient. All four do a certain amount of nursing service. All four may be drawn into the domestic problems usually handled through the social worker. And all four take a part in rehabilitation. The direction and supervision of the work should be clean cut, but the better the understanding, the more effective will be the cooperation between staff members.

The care of the patient, then, does not depend upon physical facilities alone; it depends primarily upon the sympathetic understanding and cooperation of every person involved. This can only exist in a harmonious, well-trained, well-informed, interested, and intelligent staff.

The other half of the work is the education of the patient which is carried on through personal

contacts of the staff, talks and lectures, books and periodicals on tuberculosis, sanatorium publications and visual aids of all kinds. The education of the patient starts with the day that the diagnosis is made. Then the first shock is received, and the patient's little world crumbles around him. Often he loses everything for which he has worked, saved, and planned. Usually he enters the sanatorium in a condition of mental chaos.

It is the job of every person who is in touch with this patient to sympathize, to help, to encourage, and to gain his confidence. The hope and assurance of recovery must be instilled, his family problems must be met, and his rehabilitation started at this time.

At first the patient is too stunned to appreciate or understand the rules of the game, but his education must start right at the beginning. It is important that the attitude of every staff member should be that of a teacher, giving the patient the hints and the rules which will be short cuts to recovery. Optimism should be the keynote.

When the first shock has worn off, the patient is in the mood to be a pupil in our school for tuberculosis. He will listen to other patients and get distorted ideas; he will listen to anyone and everyone. It is important, therefore, that his information be authentic. The lectures given, the books furnished, and the sanatorium publications all play an important part. If the staff is well trained, the questions can be intelligently answered. Each department head should take part of the responsibility for delivering talks and lectures.

The patient should be taught how tuberculosis develops, how it is diagnosed, and how it can be prevented. He should understand the different types of treatment and the objective of these treatments. He should be made to realize that his cure is within himself. He should be taught how the disease is spread and how to protect others. When this is done, we have reduced the hazard nearly 90 per cent. The patient should realize the importance of follow-up examinations long after discharge. He should know the length of time that it takes before he will be well, even after returning to a productive life. Too often the patient is discharged with a good prognosis from an institution, but because his education has been incomplete, he becomes careless and, as a result, his tuberculosis recurs.

The responsibility for patient education does not belong to doctors alone. It is the responsibility of every nurse, every social worker, and every rehabilitation worker who comes in contact with the patient. The sanatorium should not be a jail, but it should be a school for the education of the patient, and discipline is just as important as medication and treatment. A well-educated patient who leaves the sanatorium with consent, and is well on the road to recovery, seldom breaks down again. It is the careless patient who didn't learn the lesson who comes back to be readmitted.

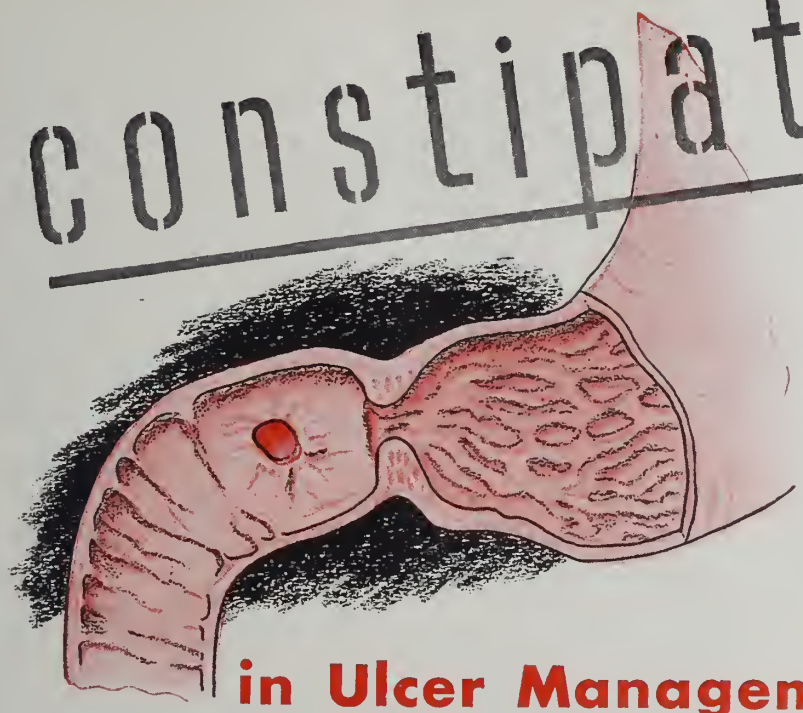
Let's Improve the Care and Education of the Tuberculous Patient in the Hospital, Howard W. Bosworth, M.D., Transactions of the National Tuberculosis Association, 1946.

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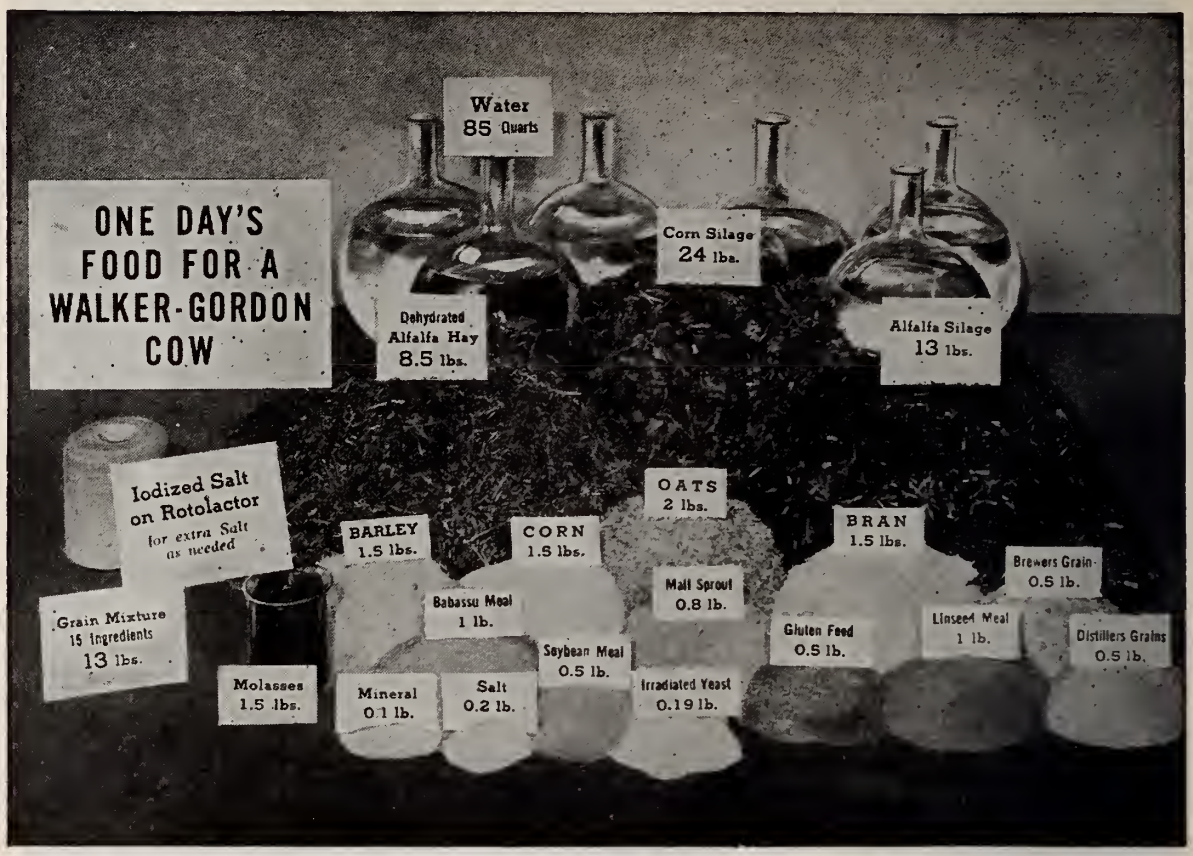
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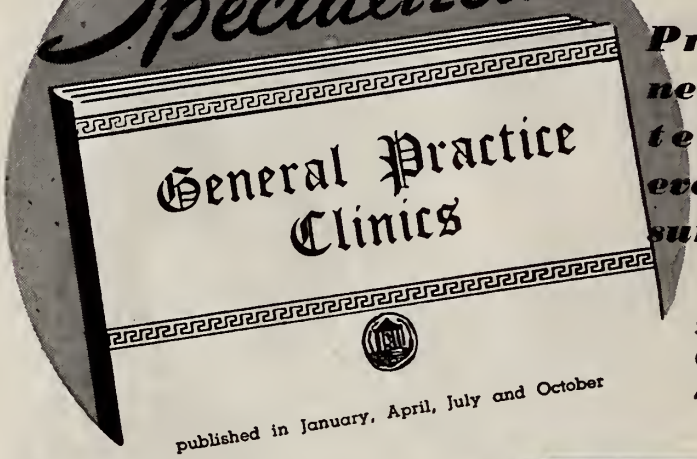
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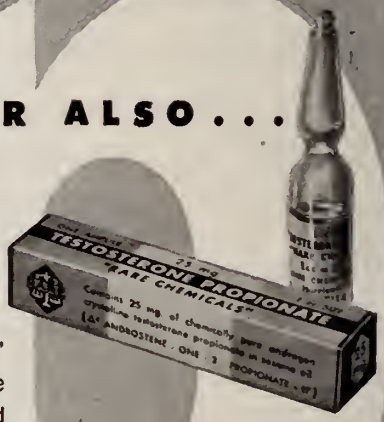
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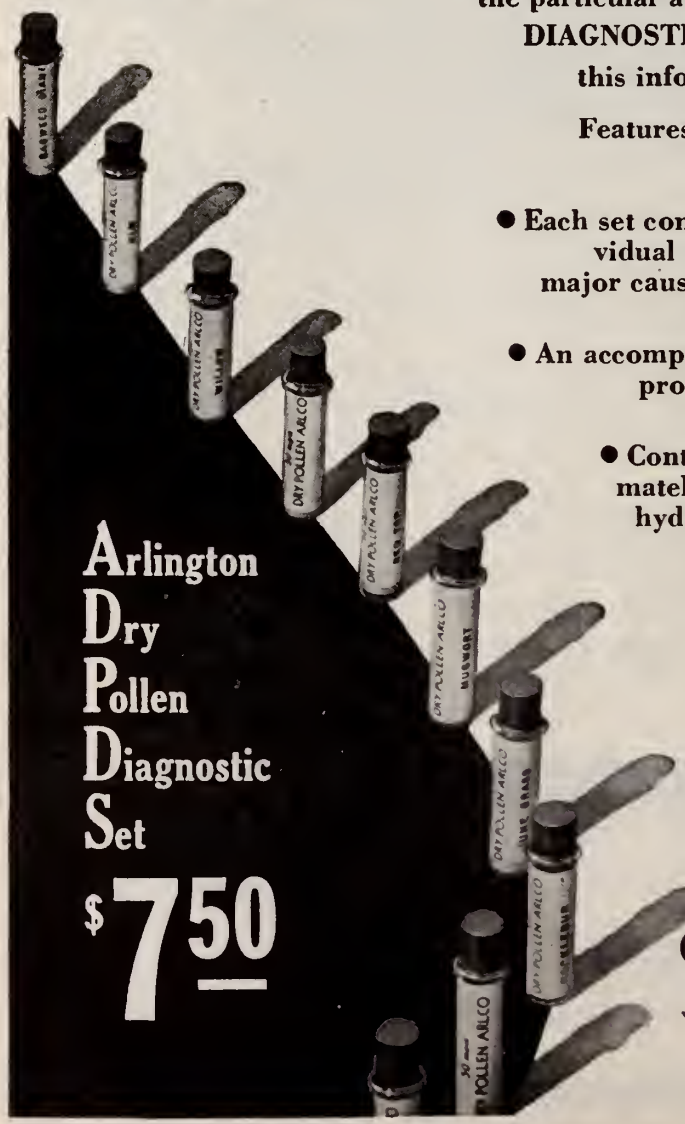
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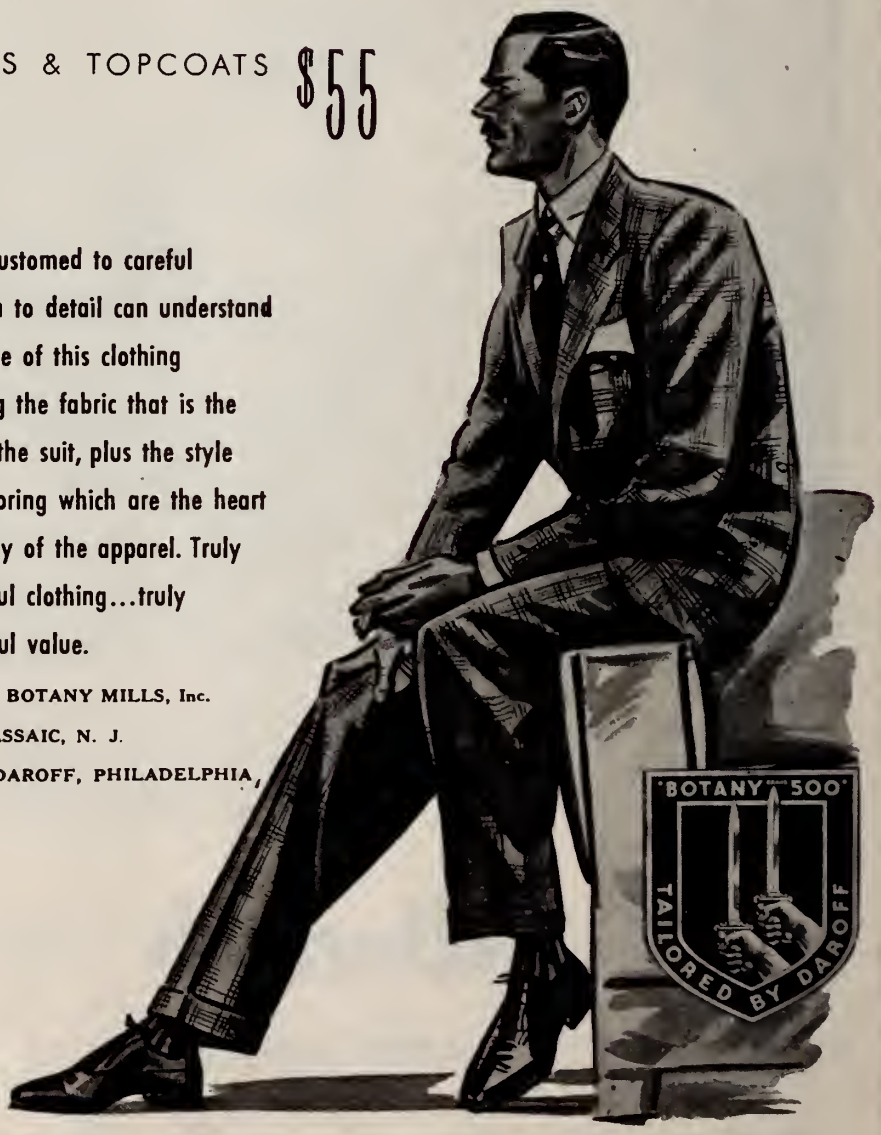
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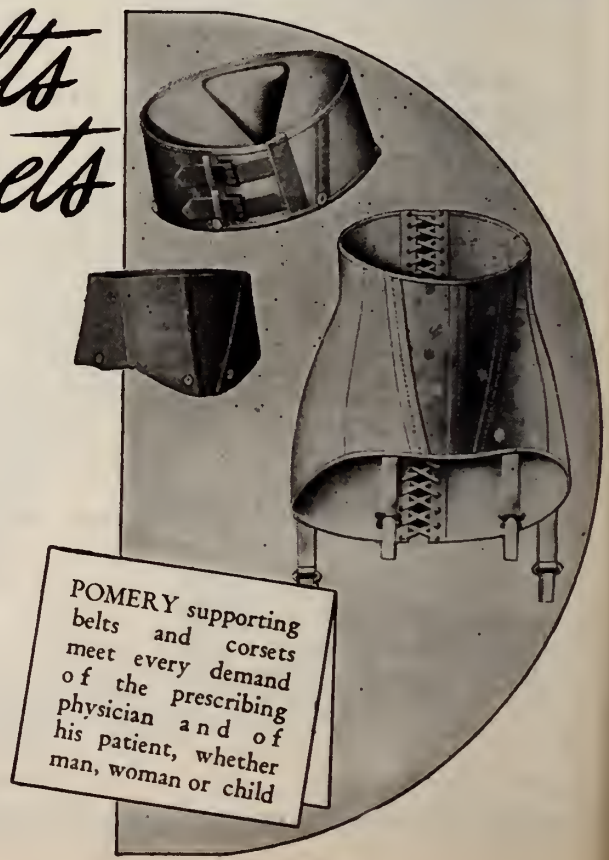
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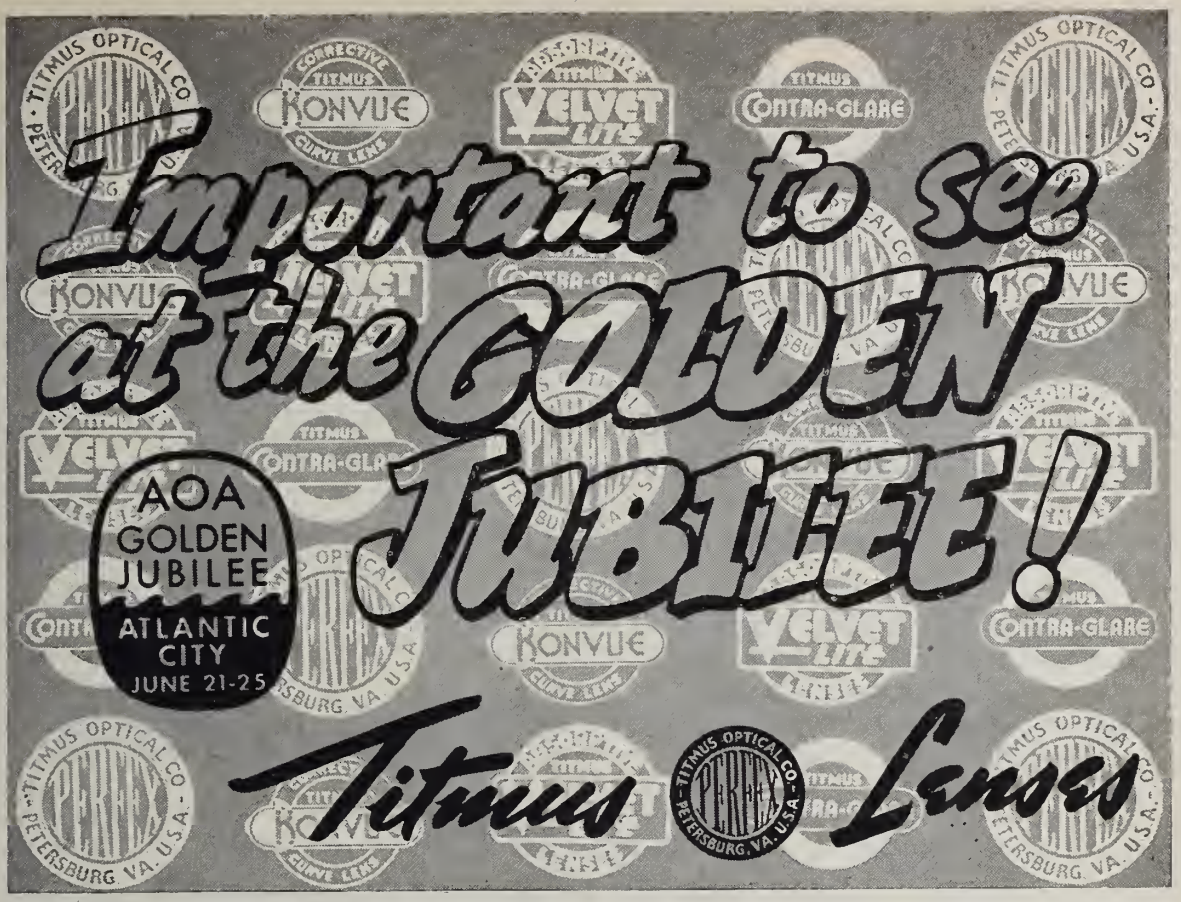
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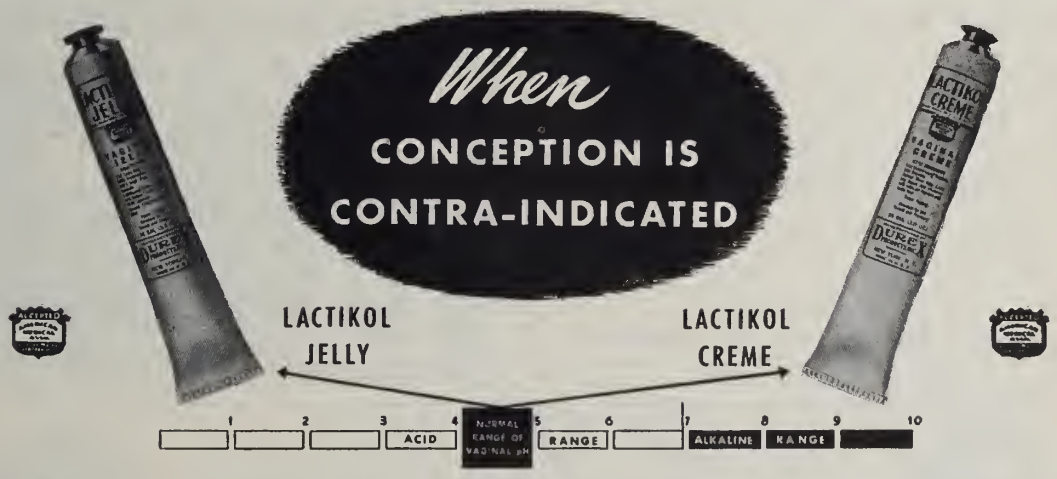
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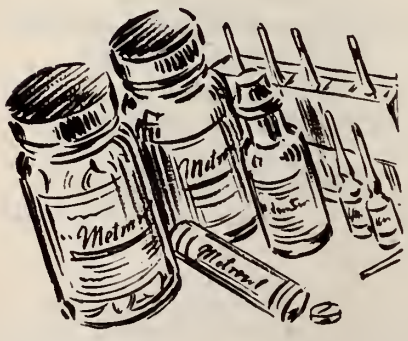
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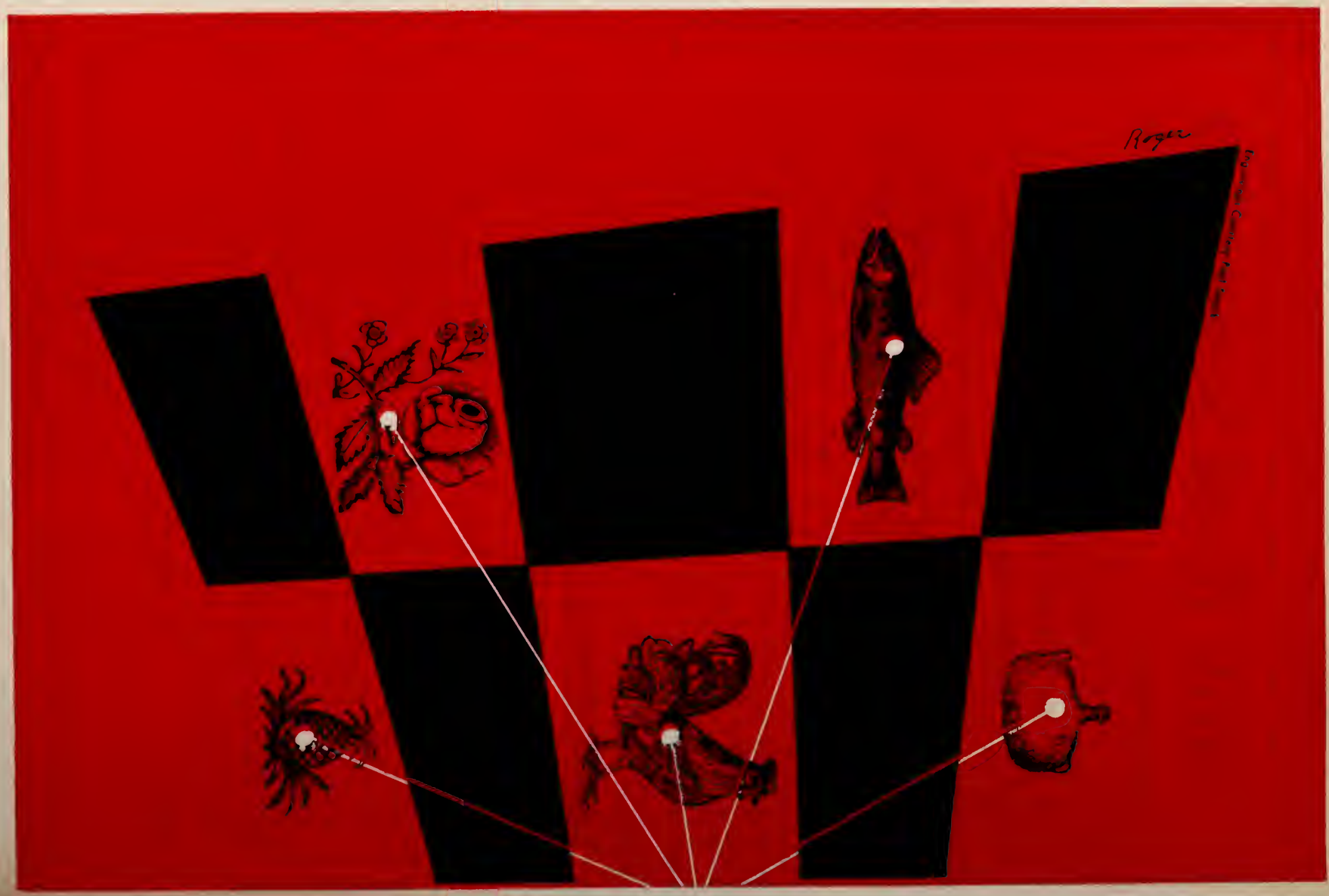
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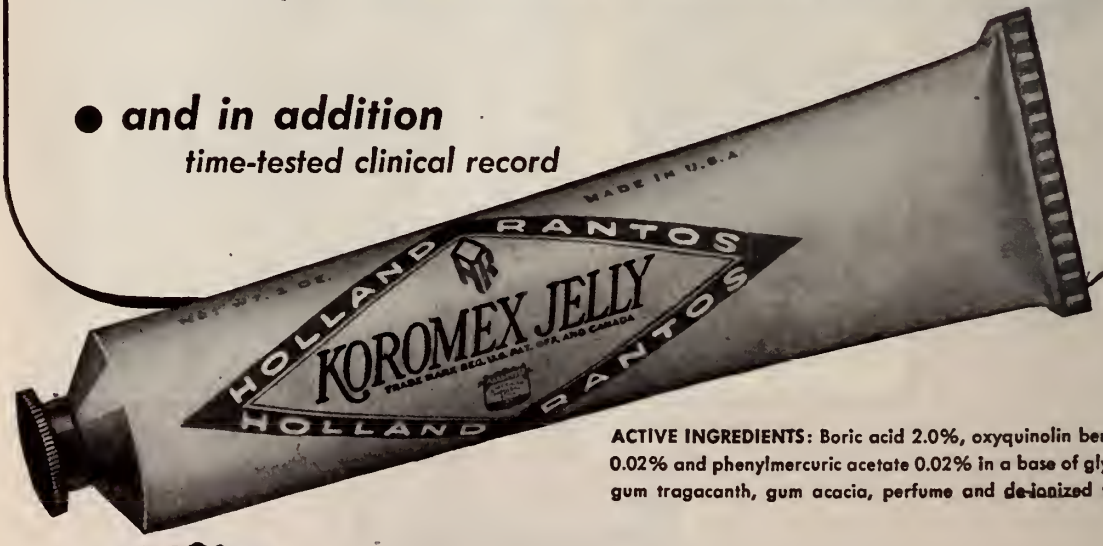
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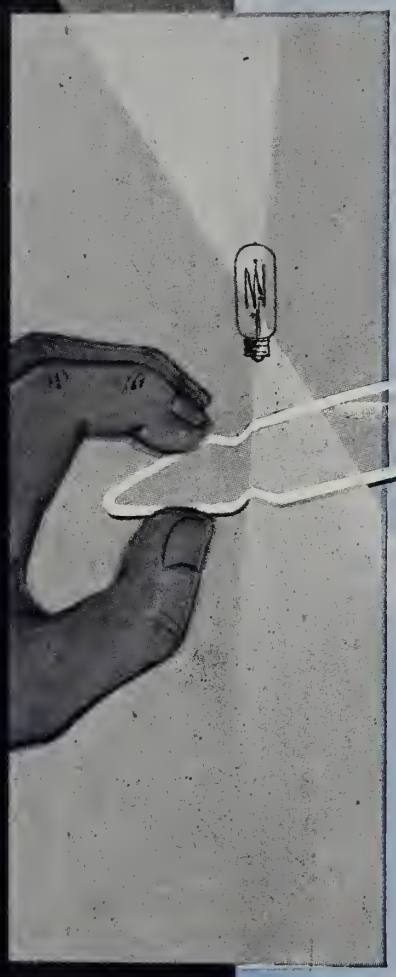
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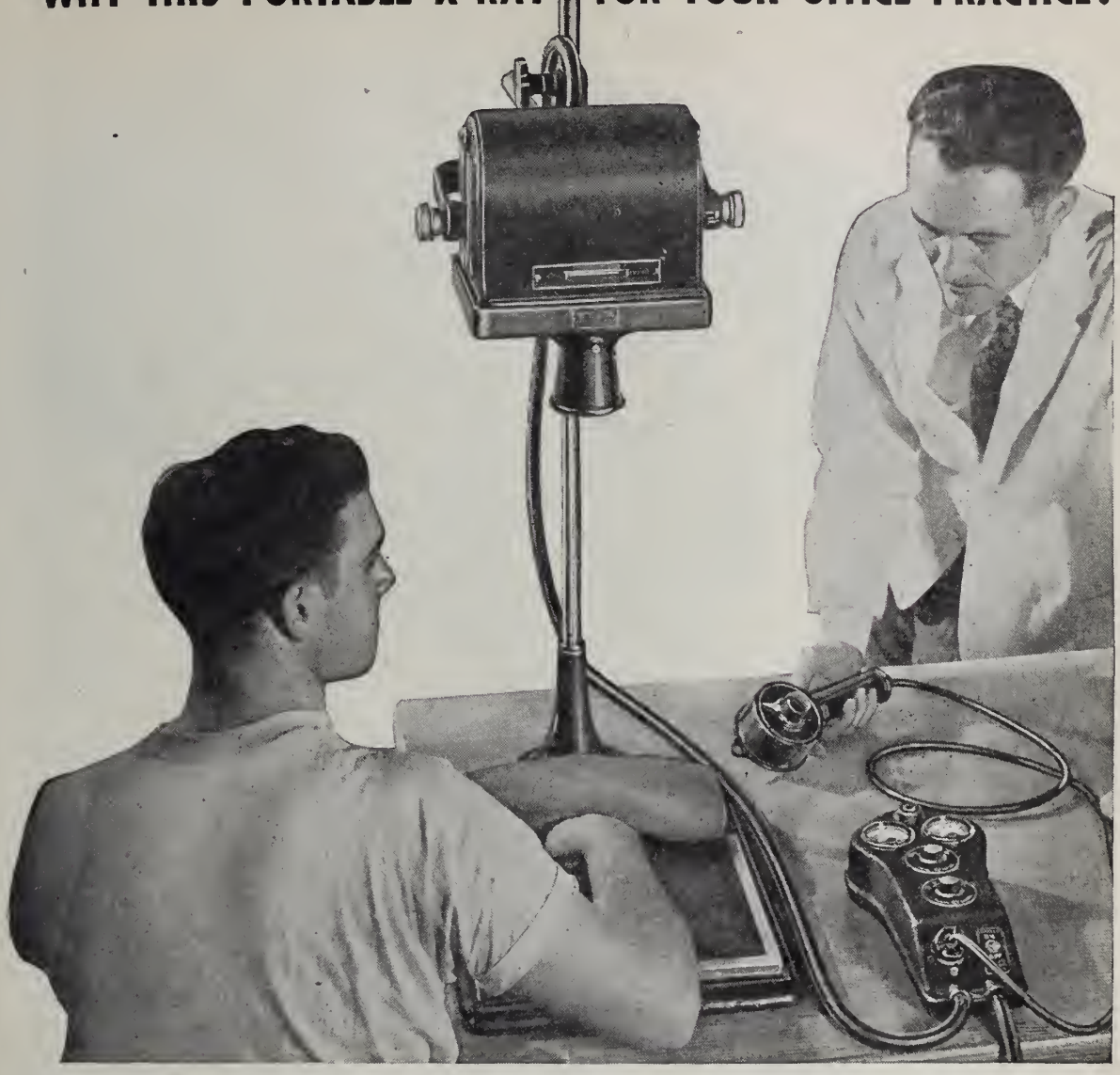
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pyribenzamine

PYRIBENZAMINE, the new Ciba antihistaminic and anti-allergic, is proving highly useful in relieving the symptoms of a wide range of allergies. Medical reports in impressive numbers show favorable clinical results in urticaria, seasonal and non-seasonal rhinitis, pruritus, and other allergic manifestations. For practical purposes Pyribenzamine can be regarded as giving a comparatively low frequency and intensity of side reactions. This permits tolerance of larger doses and enables the physician to obtain results where smaller doses are not effective.*

*Feinberg, S. M.: J.A.M.A., 132: 702 (Nov. 23) 1946.

PYRIBENZAMINE (brand of tripelennamine) Trade Mark Reg. U. S. Pat. Off.

CIBA PHARMACEUTICAL PRODUCTS, INC.

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* whenever antihistaminics are indicated

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You can now prescribe Pyribenzamine with the assurance that your prescriptions will be promptly filled.

In its comparatively low frequency of side reactions, permitting larger doses where needed, Pyribenzamine offers important therapeutic advantages whenever antihistaminic medication is indicated. This new product of Ciba research is characterized by its capacity to counteract many of the effects of histamine. It prevents and controls certain allergic manifestations believed to be caused wholly or in part by release of histamine. Its action is palliative, not curative.

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Detailed information and samples of Pyribenzamine can be obtained by writing the Professional Service Division.

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Flexural eczema. Pyribenzomine relieves itching in acute and chronic eczemataid reactians in a substantial number af cases.



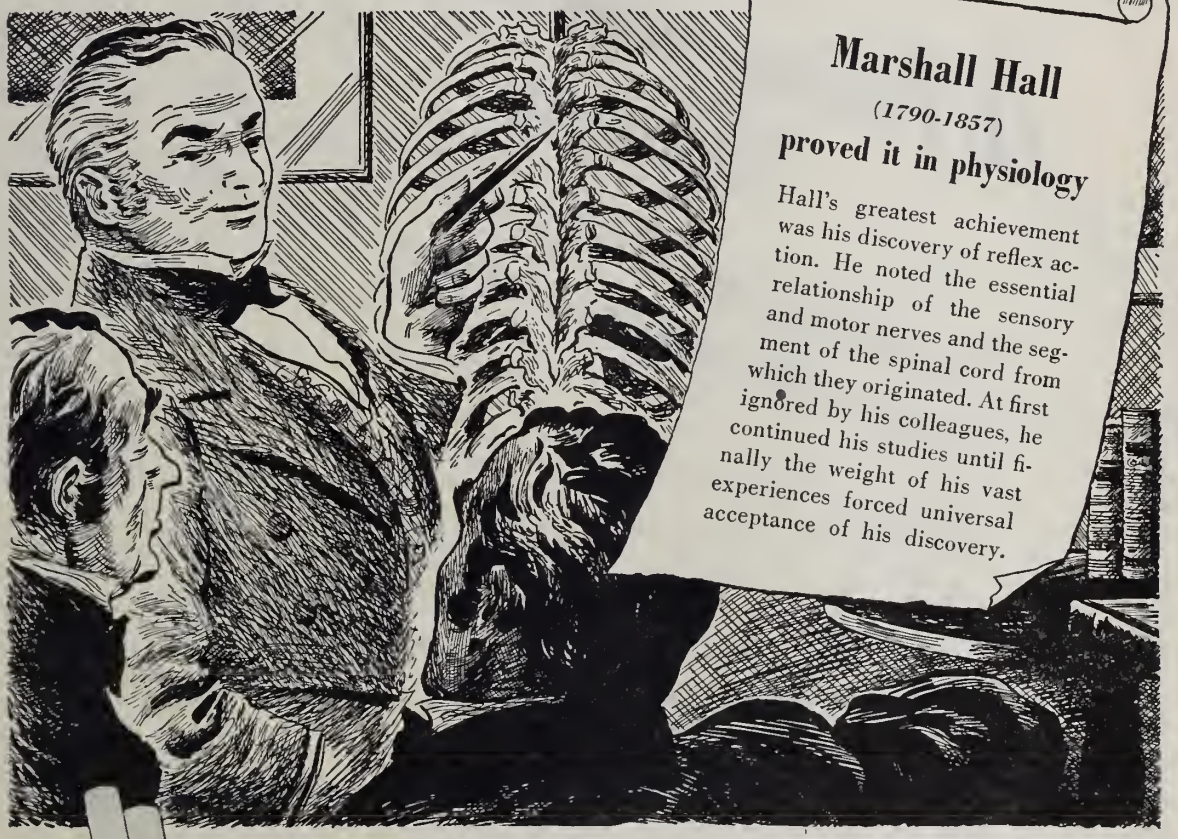
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Pyribenzamine is highly effective in cantral af itching. Eighty-five to ninety-five per cent af patients experience relief.

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Experience is the Best Teacher



Marshall Hall

(1790-1857)

proved it in physiology

Hall's greatest achievement was his discovery of reflex action. He noted the essential relationship of the sensory and motor nerves and the segment of the spinal cord from which they originated. At first ignored by his colleagues, he continued his studies until finally the weight of his vast experiences forced universal acceptance of his discovery.





Yes, experience is the best teacher in smoking too!

IT WAS their experience during the wartime shortage of cigarettes which taught people the big differences in cigarette quality. People smoked many different brands then—whatever brand was available. And so many more smokers came to prefer Camels as a result of that experience that now more people are smoking Camels than ever before. However, no matter how great the demand, *we don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.*

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These pills are engaging increased interest in neurological clinics as well as in private practice, especially in the treatment of the *Sequelae of Epidemic Encephalitis.* They embrace the full therapeutic properties of the drug in a form convenient for administration.

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They provide the indispensable amino acids in the same advantageous complete assortment as muscle meat. Hence their protein is of the same high biologic value, capable of meeting every protein need of the organism. Quantitatively their protein content is approximately equal to that of muscle meat.

For hemoglobin synthesis, liver and kidney have been found superior not only to all other protein sources so far studied but also to muscle meat itself.

All organ meats are good sources of the B-complex vitamins. Some of them, such as liver and kidney, are especially rich in niacin. Liver is also an excellent source of vitamin A.

Apparently the vital role these organs play in the functioning of the animal body is reflected in the valuable contribution they can make to human nutrition. Their frequent inclusion in the human dietary—during disease as well as in health—is amply justified.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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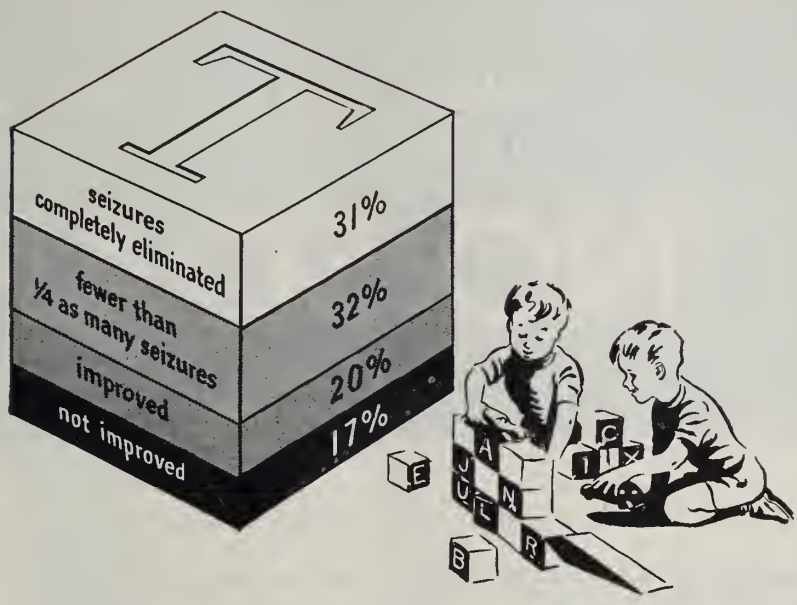
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83% of petit mal cases improve with Tridione

BIBLIOGRAPHY

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Here's new evidence of the effectiveness of Tridione in the treatment of petit mal. In a recent study, Tridione was given to 166 patients suffering from petit mal (pyknoepilepsy), myoclonic jerks or akinetic seizures.[13] This group as a whole had received but mediocre benefits from other medicaments. With Tridione, 31% of the 166 became free of seizures; 32% had fewer than one-fourth of the previous number of seizures; 20% improved to a lesser extent; 13% remained unchanged, and only 4% became worse. *Thus 83% showed improvement.* In some cases the seizures *did not return* after Tridione was discontinued, the longest seizure-free period thus far being 18 months. Studies also have shown that Tridione is of benefit to certain psychomotor patients when given in conjunction with other antiepileptic drugs.[12] Tridione is available through your pharmacy in 0.3-Gm. capsules and in pleasant-tasting aqueous solution containing 0.15 Gm. per fluidrachm. Capsules in bottles of 100 and 1000; solution in 1-pint and 1-gallon bottles. If you wish to know more about Tridione, just write to ABBOTT LABORATORIES, North Chicago, Illinois.

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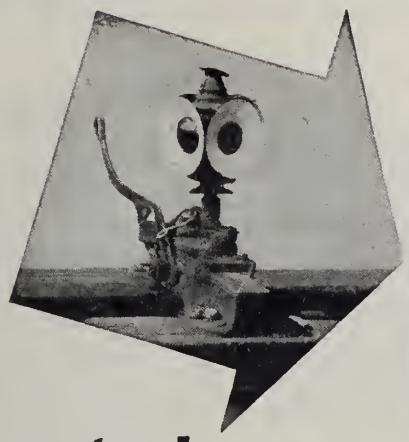
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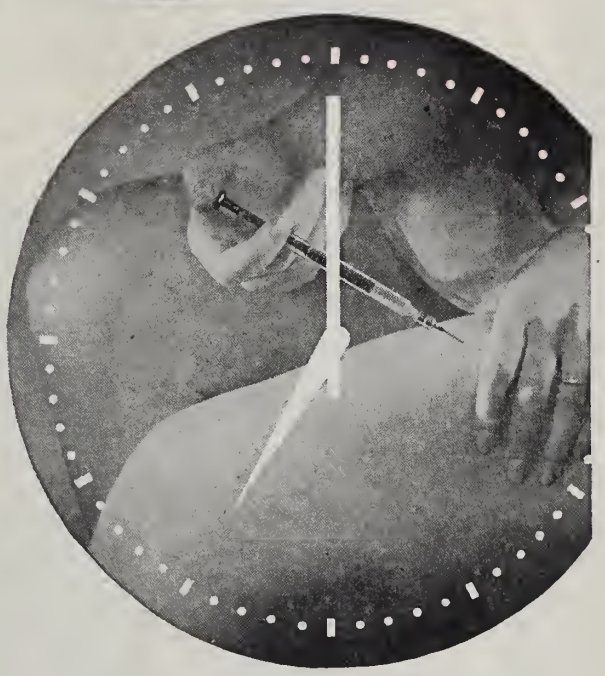
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Some things you would like your patients to know

about Epilepsy

The educational message on Epilepsy, shown below, will appear in full color in LIFE and other national magazines . . . reaching an audience of more than 22 million people. This is No. 205 in the "See Your Doctor" series, published by Parke-Davis in behalf of the medical profession.

Some things you should know about epilepsy

No. 205 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.

EPILEPSY is one of the most widely misunderstood of all diseases.

Many people believe that there's no effective treatment for it, that it's a kind of feeble-mindedness, that it always becomes worse as the patient grows older, and that he has no chance of leading a normal life.

Your doctor, however, will tell you these ideas are false.

The truth is that medical science has accomplished a great deal in its attempt to control epilepsy, and today the outlook for most persons who have the disease is distinctly hopeful.

What is epilepsy?

In broad and simple terms, epilepsy is a disorder in which the patient suffers recurrent nervous seizures. These seizures—usually characterized by muscular convulsions and sometimes by the loss of consciousness—vary greatly in frequency, duration, and intensity.

The fundamental cause of epilepsy is unknown, although a variety of contributing causes have been established.

Contrary to popular belief, heredity as a rule does *not* play the major role in epilepsy. The chances that an epileptic will have an epileptic child are only about one in forty.

Can epilepsy be controlled?

Epilepsy most often begins in childhood or adolescence. In times gone by, a diagnosis of epilepsy was a dreadfully heavy blow. But today the doctor can usually give the parents—and the child—much encouragement and hope. The following figures explain why this is so:

In approximately one out of six cases, the disease eventually disappears—and disappears completely.

Where the disease does not disappear, nearly 50 per cent of the patients are—with proper medical care—entirely free of seizures. Another 25 per cent or so can be almost entirely free, and can lead a virtually normal life.



The treatment of epilepsy

In most cases, modern drugs are the doctor's chief weapon. *Only the doctor knows which drug or drugs should be used, and in what dosage.*

Using these medicines, the doctor has been able to give epileptics a new lease on life. Once haunted by the threat of seizures and the danger of gradual mental deterioration, they often spent their days in tragic seclusion. But now most of them can lead normal lives. They can work, swim, dance, and play golf or other games. Children can go to regular schools and are able to study and play on a par with their schoolmates.

SEE YOUR DOCTOR! If you or your children ever experience a seizure — however mild — *see your physician promptly.* With epilepsy, as with any other disease, he can be of greatest help when you give him a chance to fight the ailment in its *earliest* stage.

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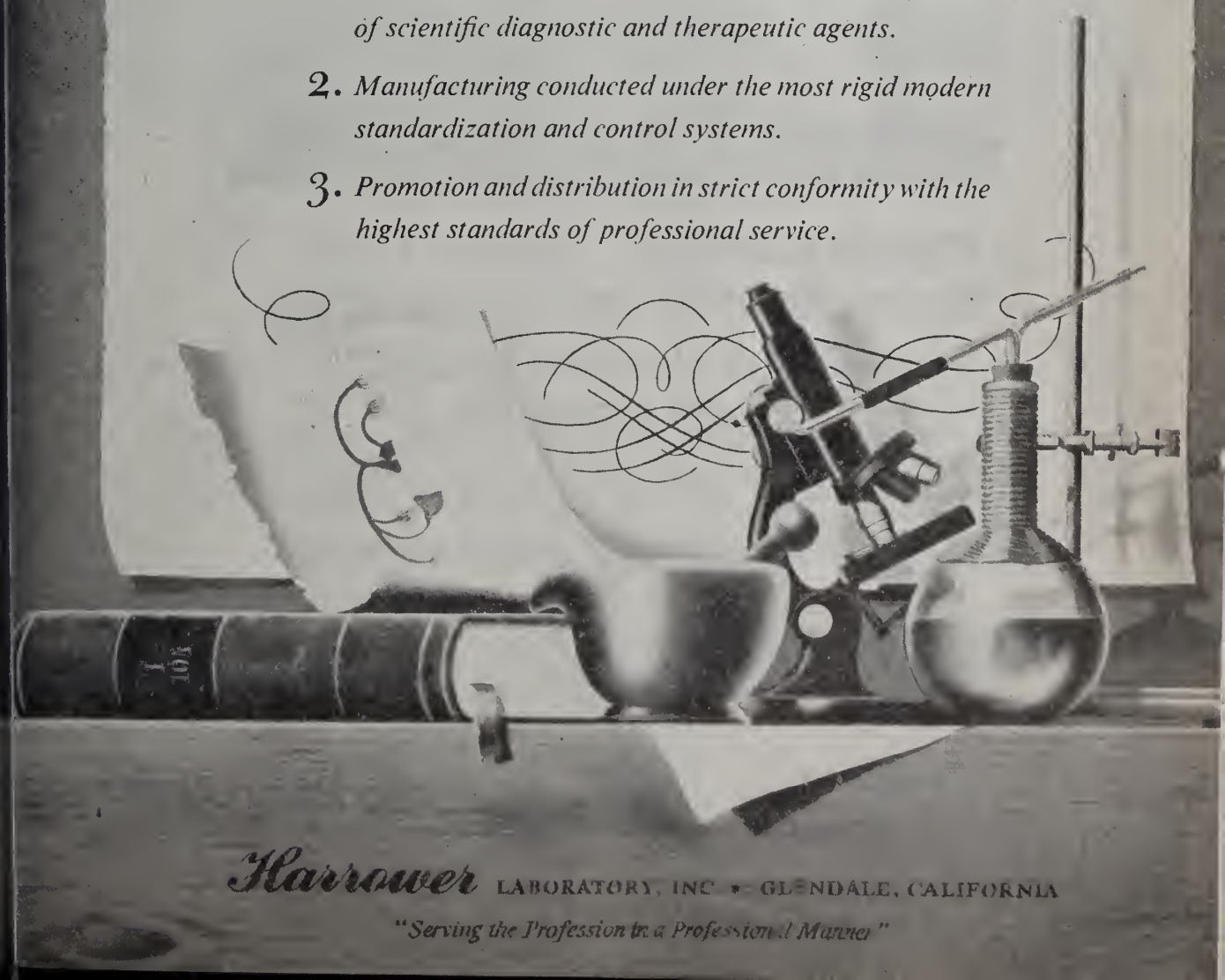
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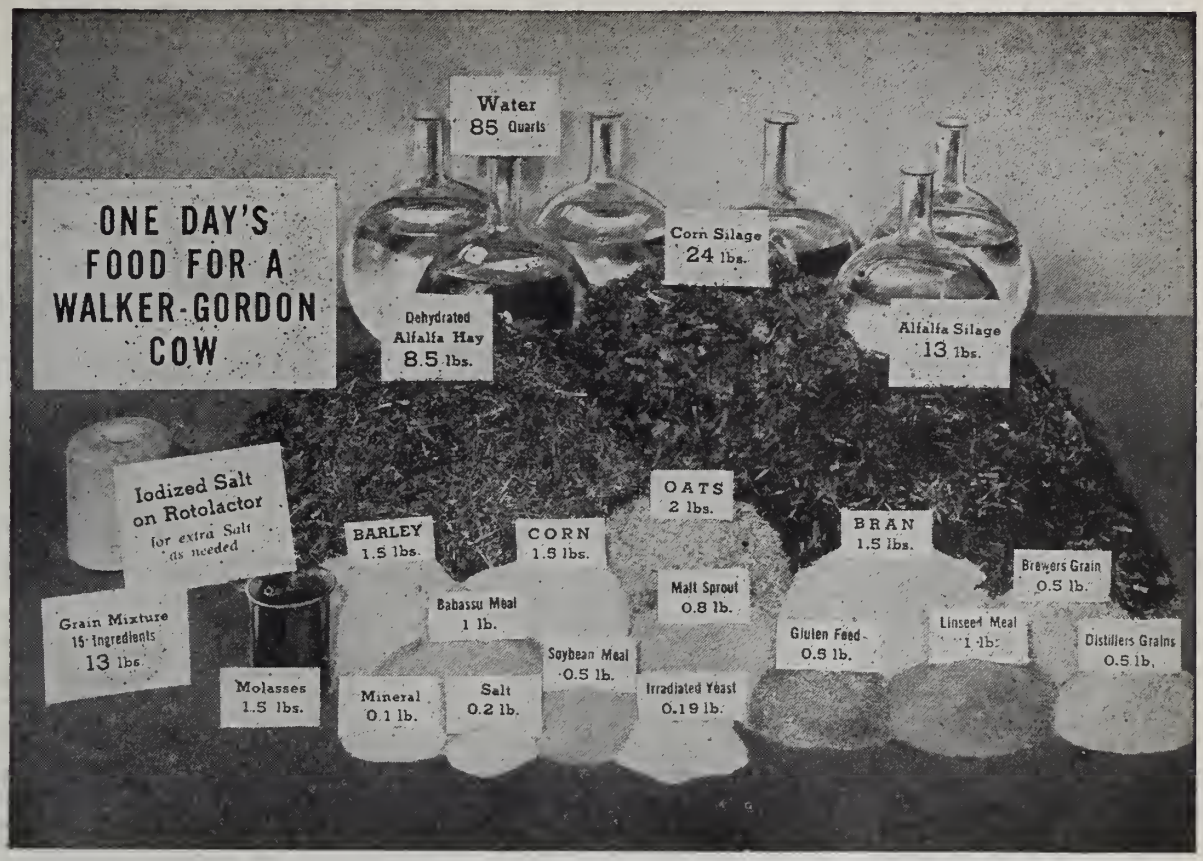
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THIS SCIENTIFIC daily ration was developed after years of study by the Walker-Gordon Laboratories.

It's remarkably rich in vitamins and health-giving minerals . . . And that's one big reason why Walker-Gordon cows produce a milk far superior to the type you get from cows that are fed in the ordinary, unscientific way.

Take Vitamin A, for example. The alfalfa fed a Walker-Gordon cow is not ordinary alfalfa, but a special dehydrated kind containing 700% more Vitamin A. As a result, her milk contains 60% more Vitamin A than many ordinary milks.

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SWIFT'S STRAINED MEATS provide complete, high-quality proteins, plus desirable palatability



When surgery, injury or disease indicates chemically and physically non-irritating foods in a high-protein, low-residue diet, Swift's Strained Meats offer a highly *palatable*, *natural* source of proteins, B vitamins and minerals in easily assimilated form.

The six kinds of Swift's Strained Meats: beef, lamb, pork, veal, liver and heart, provide a tempting variety that appeals to patients, even when normal appetite is impaired.

Finely strained lean meats—prepared for infant feeding

Designed to be fed to young infants, these all-meat products are soft, smooth and moist—Swift's Strained Meats are actually fine enough to pass through the nipple of a nursing bottle. They are well adapted to use by patients who cannot eat meat prepared in the ordinary manner . . . may easily be used in tube-feeding. These products are prepared from selected, lean U. S. Government Inspected Meats, carefully trimmed to reduce fat content to a minimum. Swift's Strained Meats are slightly salted to enhance the natural meat flavor. They require no cooking—come all ready to heat and serve. Each vacuum-sealed tin contains 3½ ounces of Strained Meat.

Swift's Diced Meats

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Swift's Diced Meats also offer six appetizing kinds: beef, lamb, pork, veal, liver and heart. 5 ounces per tin.



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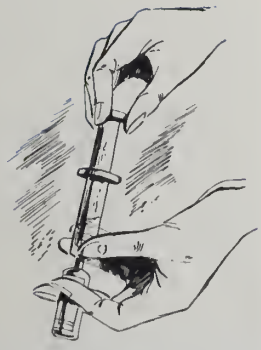
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THE PRESIDENT'S PAGE

THE DISTRIBUTION OF MEDICAL CARE

The complexion of Congress was so altered by the election of 1946 that it now seems unlikely that any action will be taken on the new version of the Wagner-Murray-Dingell Bill or other bills with similar objectives. Organized Medicine has been given a "breathing spell" for at least two years, but this does not mean that we may safely relax our vigilance and rest on our oars. The proponents of socialized medicine have lost the first battles but *we* have not yet won the war! Our opponents are well organized and directed—their aims and purposes are clearly defined—they are shrewd, resourceful and determined. Some of them are firmly entrenched in key positions in the federal bureaus concerned with health, welfare and social security.

In planning our campaign, we must abandon our defensive tactics—vigorous opposition without constructive counter proposals—and assume the offensive by developing and supporting our voluntary sickness and hospital insurance plans, for the middle income group and reimbursement plans for the indigent and medically indigent groups. The Medical Society of New Jersey has been a pioneer in these fields and we, in this state, can point with pride and confidence to our achievements. Our Medical-Surgical Plan is a thriving organization with adequate reserves to make it financially sound. It is growing as rapidly as we wish it to, the first consideration being the solvency of the plan. The success of the Newark Plan—a "reimbursement plan"—operated by our Medical Service Administration, has been most remarkable having received the enthusiastic approval of Commissioner Brady, Dr. Craster, the

participating physicians and—more important—the patients! Incidentally, the cost of the plan has been considerably lower than under the old district physician program. The success of this venture should encourage other large cities to adopt similar plans as a means of bringing adequate medical care to the sick poor.

Whenever we have an opportunity, let us make it clear: (1) That we of the medical profession in New Jersey are fully aware of our responsibility for leadership in the effort to bring adequate medical care to all of our people. (2) That we subscribe wholeheartedly to the principle that every person must receive necessary medical care for a price which he can afford to pay. (3) That we advocate voluntary sickness and hospital insurance for all who can afford to pay the premiums, and (4) That we advocate reimbursement plans for the care of the sick poor—the funds to be provided by municipal, county or state tax appropriations when possible, with supplemental funds obtained from the federal government in the form of grants-in-aid to states where the need has been demonstrated.

The foregoing program is a vigorously positive one—we have shown conclusively that it is working satisfactorily in New Jersey. With time, patience and persistence on our part, everyone in the state will have adequate medical care *without* socialized medicine. Let's "keep rolling along!"

Royal A. Schaaf, M.D.
President The Medical Society
of New Jersey.

NEW EXECUTIVE OFFICER FOR MEDICAL SOCIETY

The long search for a qualified Executive Officer came to an end last month when, on June 16, 1947, President Schaaf, on behalf of the Board of Trustees, announced that Mr. James E. Bryan had been appointed to that post. Mr. Bryan is the son of Joseph H. Bryan, M.D., one of Asbury Park's senior practitioners, honorary member of the Monmouth County Medical Society and formerly president of the State Board of Medical Examiners. Mr. James Bryan comes to us after seventeen years in medical administration. For twelve years he served as Executive Officer of the Westchester County (NY) Medical Society and for the past three years was Executive Secretary of New York County Medical Society. He was Managing Editor of *New York Medicine*, and Director of Public Relations of the Coordinating Council of the five medical societies of Greater New York.

THE COUNTY IS THE CONTACT POINT

In most countries, the local medical societies are but "branches" of the national medical organization. The triple-decker system of independent county, state and American medical associations is peculiar to the United States. It has the dual advantage of flexibility and democratic control. The A.M.A. is only a league of state medical societies: a "federacy of its constituent associations" as the A.M.A. Constitution words it. Thus the A.M.A. has no existence apart from the state societies which compose it: a fact which discourages any efforts to set up dictatorial control from the top. And in like manner, each state society is only a league of its county components. In the last analysis all power flows from and

originates in the county medical society.

County societies generally suffer from a surfeit of modesty. Their officials feel that the small organization must look to the state society, if not indeed to Chicago, for policies and advice. And while it is true that by reason of size and coverage, state societies can do many things not available to the smaller units, it is equally true (but usually forgotten) that there are some functions which the county societies do better.

The county society is the contact point between the physician and organized medicine. The doctor "belongs" in a personal sense to the county society only. His membership in the A.M.A. and in the state society is secondary to, and derivative from his membership in the county society. Only the county society has meetings wherein each member has a vote in his own right. At the higher levels, only delegates vote and participate in proceedings; at the county level on the other hand, one doctor's vote counts as heavily as his colleague's.

The county society is also the best contact point between organized medicine and the public; and between organized medicine and legislator. Almost every congressman, assemblyman and senator in the country has as his personal health adviser a member of some county society. The local newspaper, the small business man, the school teacher, the town banker, the labor union executive, and the housewife, all of these people—our "public"—are obviously in closer contact with the county society officials than they are with the state and national organizations. If, as it is said, democracy has grass roots, then in the hierarchy of organized medicine, the county society is right at those roots.

Overshadowed by the more elaborate machinery available in state and national societies, county organizations often forget that they have prime facilities for a public relations job that will yield swift dividends. If there is local uneasiness about the sanitary conditions in the town's restaurants, the county society may offer to do the investigating and inspecting. If the local newspaper delivers an editorial blast at the profession, the county society can make the rebuttal long before the slower machinery at the state level can get into gear. If the service club or P.T.A. wants a health speaker, the county society can, and should furnish local medical talent.

Doctors in general are suspicious of excessive centralization. The cause of home rule can be immeasurably strengthened if county societies would function vigilantly and consistently at the local level. Even grass roots wither if not regularly attended.

TOWN MEETING FOR NEW JERSEY DOCTORS

It is planned to make the next Annual Meeting a platform for practitioners, a true town meeting of medical progress. As a matter of fact, Annual Meetings of The Medical Society of New Jersey have never been isolated playgrounds for esoteric specialists. By and large the program has usually been down-to-earth. The Annual Meeting Committee is particularly interested in getting wide representation among New Jersey practitioners at the exhibits and reading stands in the 1948 convention to be held April 26-29, Haddon Hall, Atlantic City.

If you have an exhibit to display, an idea to promote, a paper to read, this is the time to start planning the details. Communicate now with the Annual Meeting Committee (Executive Offices, The Medical Society, 315 West State Street, Trenton 8, N. J.) so that your suggestions will be on the agenda when the Committee starts to build the program for next April.

ETIOLOGY OF SCLERODERMA
A PRELIMINARY CLINICAL REPORT

Virginia Wuerthele-Caspe, M.D., Eva Brodkin, M.D., and
Camille Mermod, M.D., Newark, N. J.

This is a preliminary report on a probable bacterial cause of scleroderma and on its further treatment with an antibacterial agent. As indicated in a previous report,[1] we had reason to suspect a bacterial origin of scleroderma. On the supposition that the organism is a mycobacterium as in leprosy and tuberculosis, the senior author reasoned that it should be found in nasal ulcers, subcutaneous tissue, and sputum when there is pulmonary involvement. Accordingly material was prepared from the sputum of a proved case of scleroderma (case three below). When the slides were stained by the Ziehl-Neelson method, numerous short, thick, acid-fast rods appeared. Aid in identifying the organism found in this case and the others mentioned here was obtained from Dr. Eleanor Alexander-Jackson of Cornell University Medical College through the application of her differential triple stain technic. At this point, a cooperating team of investigators was formed to identify this organism, study its pathology, and outline a course of study. The following case histories show the results of this study.

CASE ONE

A white female, age 52, had sclerodactylia with ulcerations of the fingers for nine years. This was confirmed by biopsy. She received hytakerol (dihydrotachysterol-Winthrop) for five years with some arrest of progress initially but no effect finally. Multiple petechiae of the mucous membranes were present. She was then treated with local applications of promin jelly (5 per cent promin in tragacanth —Parke, Davis) with healing of the ulcerations and marked improvement in the flexibility and use of the hands. She is now able to resume her occupation as nurse. Nasal smears reveal a mycobacterium. Blood culture in Dubos' medium after two weeks growth, showed a pure culture of short, thick, acid-fast rods. The present status indicates retrogression of the local condition since the hands are essentially healed, but a generalized systemic infection is evidenced by the positive nasal smear, the presence of recurring petechiae, and a positive blood culture.

CASE TWO

This is a 58-year-old white female who has had scleroderma for twenty years . Four years ago, she had an operation for pituitary tumor. She was blind, emaciated, uncertain in her walk, and had the typical appearance of scleroderma: stiffness of the joints, premature senility, intractable nerve pain, telangiectases, atrophy of the skin, persistent, agonizing itching, and deep ulcerations of the ankles and feet. X-ray of the chest was negative but at the proximal inch of the left clavicle, there was a cyst-like lesion and an area of decreased density with definite thinning of the cortex. This is said to be characteristic of scleroderma in bone. Because she was in the terminal stage of the disease, intravenous promin was not used. Promin jelly was applied liberally three times daily to the lower extremities which were then covered with cotton stockings. Within ten days, the itch was lessened, the ulcers began to heal, giving her the first relief she had had in many years. At the time of her death, eight weeks later, the ulcers were largely healed. No bacteriologic work was done and no autopsy obtained.

CASE THREE

A white male 55 years old first complained of puffiness of the hands. Shortly thereafter, his joints became stiff. His skin became darkly pigmented. Doughy indurations appeared over the abdomen. The skin over the chest became atrophic, hard and tight. His hands began to thicken; the fingers became hard, cold and club-like. He was told that he had scleroderma, and biopsy was positive. Hytakerol effected some relief but did not arrest the progress of

1. Wuerthele, Virginia: Journ. Med. Soc. N. J., 44: 52, February 1947.

the disease. Within two years, he had developed a severe cough. This was a matter of serious concern, because patients with scleroderma sometimes die of pulmonary involvement.[2] Roentgenograms on February 27, 1947, showed irregular areas of density in apices of both lungs, suggesting fibrosis. The lungs had a uniform "ground-glass" appearance. Small dense areas of calcification were observed in the extreme outer third of each lung field. The right apex shows a small, exudative area with a central highlight which may be a cavity or cyst. The x-ray of May 15, 1947, shows that the previously noted exudative area has been replaced by a star-shaped area of fibrosis such as is seen in the healing of tuberculous lesions. Repeated sputa examined by the Board of Health were negative for tuberculosis. The tuberculin test was negative. In the sputum from this patient, we found short, thick acid-fast rods. The same rods were found in the sterile subcutaneous smears. A nasal ulcer was present, and smears from this area revealed mycobacteria. This patient has been treated with promin tablets orally (one gram daily) for three months. Despite the inadequate dosage, since promin and promizole tablets are unobtainable at present, lung healing progressed. Promin intravenously should be given daily, but this is not possible in an advanced case of scleroderma because of toughened skin and damaged blood vessels. When this patient's dose was increased he had a reaction he described as a severe itching, crawling, burning sensation throughout the subcutaneous tissues of the entire body. This reaction has been described during the course of treatment of leprosy and has been interpreted as a possible Herxheimer reaction due to a rapid lysis of the bacteria. Nasal smears from a leper taken during this reaction show the lepra organisms undergoing toxic degeneration. We believe our patient had a similar reaction since the blood culture taken at this time was negative although the nasal and subcutaneous smears were positive. After this reaction, we resumed the drug and increased the dose, and this time there was no further untoward reaction. At present, the man is taking a gram of promin daily, by mouth. Cough has diminished and he no longer needs sedation. Promin, like other sulfonamides, decreased the red blood count and hemoglobin, and this patient has had one transfusion since the beginning of this treatment.



CASE 3. Before promin treatment. Feb. 25, 1947.



CASE 3. After treatment. May 15, 1947.

CASE FOUR

A 48-year-old white female had arteriosclerosis with sclerodermatic changes. She exhibited restriction in the motions of all digits, and board-like infiltration of the entire cir-

2. Wuerthele, H. W.: Pittsburgh, Penna., in personal communication to the authors, reported three pulmonary deaths in scleroderma patients. Cystic sclerodermal changes in the lungs have been found by A. Dostrovsky, Archives of Dermatology and Syphilology, January 1947.

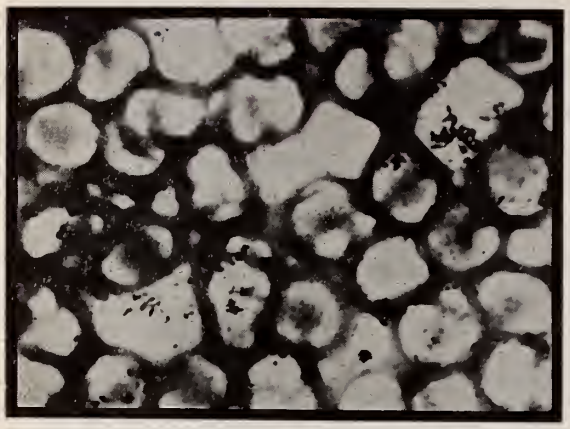


PLATE 1. Acid-fast rods from fulminating case Ziehl-Neelson direct blood smear.

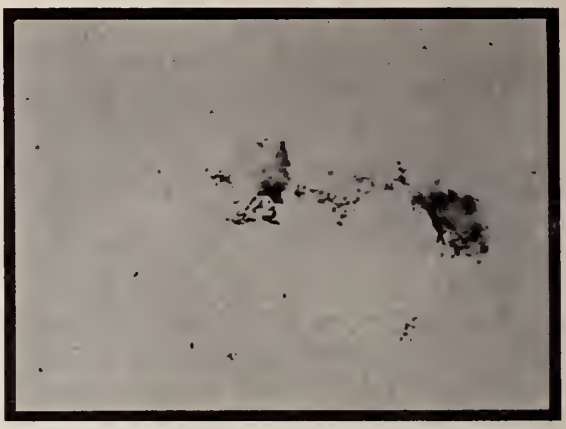


PLATE 4. Sputum acid-fast rods Ziehl-Neelson stain. Case 3.

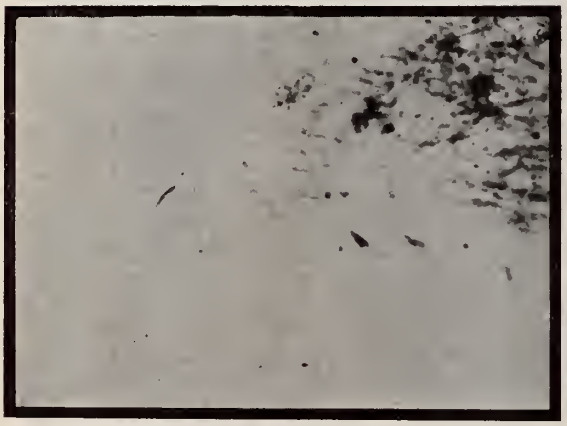


PLATE 2. Acid-fast rods—nasal ulcer of leper.

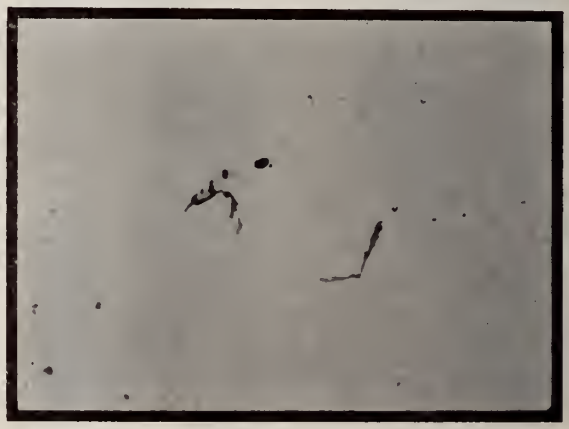


PLATE 5. Acid-fast rods from finger ulcer.

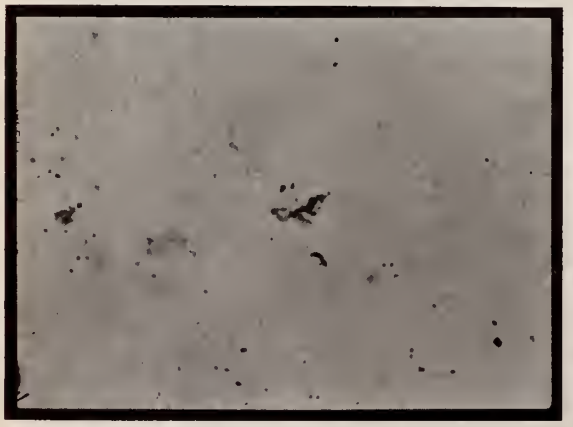


PLATE 3. Pure culture from blood in Dubos' medium. Case 1.

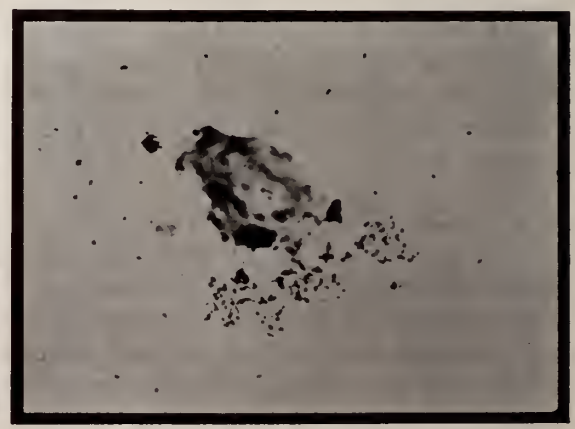


PLATE 6. Nasal ulcer smear—case of scleroderma—acid-fast rods.

cumference of the right arm. Bilateral periarterial sympathectomy (Leriche) of the upper extremities has been done with no permanent result. The disease has been present more than six years, and has been confirmed by biopsy. This patient had one usable vein in the left arm. She received promin intravenously daily, the dose being increased gradually from 0.2 grams to 2 grams. When she received the latter dose she developed a severe reaction similar to that of case three. At the site of the involved areas (the right arm and shoulder girdle), there was marked redness, swelling, and pain. The center of the areas remained white (where there were fibrotic changes) but the periphery became edematous and reddened. Pain along the nerves was severe. No relief was obtained from sedation or benadryl. Gradual subsidence occurred in three to four days. In addition, she appears to have developed a sensitivity to the drug, which has been discontinued. No blood or subcutaneous smears were taken but nasal smear showed the presence of mycobacteria from an ulcer on the septum.

CASE FIVE

This is a 26-year-old colored female who has had scleroderma for eight years. It has been confirmed by biopsy. She has irregular areas of skin pigmentation, stiffness of all joints, and recurrent ulcers of the fingers, knuckles, elbows and other parts of the body. She exhibits linear areas of atrophy over the hands, arms and trunk. The entire skin is hard and tight. Epistaxis is frequent, and she has ulceration of the nasal septum and multiple petechiae of the mucous membranes and of the skin over the chest. She has lost twenty pounds and cannot raise her arms above her head. Nasal and subcutaneous smears show an acid-fast bacillus.

CASE SIX

A 64-year-old white female, housewife, has had changes in the hands similar to those found in Raynaud's disease. In the last two years, the fingers have become stiff and pale with swelling of the interphalangeal joints. Recently, she has had marked pain with ulceration on the tips of the left fifth finger and the right thumb. Petechiae appeared to the wrist on both hands. Promin jelly was applied with relief of pain in two days with beginning healing of the ulcers and gradual disappearance of the petechiae in two weeks. She has developed a cough with coarse rales throughout both lung fields.

There is a shallow, wide-spread rough ulceration on the left side of the nasal septum which shows many mycobacterial forms on smear. Acid-fast rods are seen on smears from the finger ulcerations. The blood shows mycobacterial forms as well.

SUMMARY AND CONCLUSIONS

1. An acid-fast bacillus has been found in five cases of scleroderma examined bacteriologically.

2. The organism has been found in the sputum, blood, nasal and subcutaneous tissue smears, and has been grown in pure culture from the blood.

3. All patients treated with promin (which destroys or inhibits mycobacteria) have shown definite, responsive changes.

4. The organism has been tentatively named *sclerobacillus Wuerthele-Caspe* and may be a newly recognized member of the family of mycobacteria. Further bacteriologic and therapeutic studies are now in progress.

ACKNOWLEDGEMENTS

Acknowledgements are due and are gratefully made to Dr. Royal A. Schaaf of Newark (for case 2), to Dr. Jacob Bleiberg of Newark (for case 3), to Dr. S. L. Rosenstein of Vauxhall (for case 5), to Doctors Bernard Sirotti of Paulsboro, N. J., and J. M. Schoenfeld of Norfolk, Virginia (for case 4), to Dr. Joseph Caspe of Newark (for the microphotography and microscopy), to Doctors Henry Brodkin and Allen Welkind of Newark (for x-rays) to Mr. Julius Weber of the Presbyterian Hospital (for the photomicrography) and to Dr. Richard Dieffenbach of Newark (for reading the chest x-rays).

560 Mt. Prospect Avenue
365 Osborne Terrace
15 Washington Street

BRIEF PSYCHOTHERAPY *

Elsworth Baker, M.D., Marlboro, N. J.

Brief psychotherapy is a technical procedure of a palliative character, aimed at relieving the patient of certain symptoms that are painful or dangerous, or designed to help him handle a given situation or problem. Deeper changes in the personality are not attempted. Instead of reforming from within, we do more supporting from without. This limited goal must be achieved in a small number of well-timed interviews. Anyone who can be reached can be treated by brief psychotherapy. It is recommended roughly, for those too sick or too well to undergo standard analysis or those who cannot afford the time and money necessary for this procedure. Psychoanalysis is a more thorough therapy and is preferable where feasible.

The cooperation of the patient is essential and the individual must have the ability and willingness to make the changes necessary in solving disturbing problems. This involves insight, i. e., the need and wish to be helped and a reasonable ego strength. Ego strength may be defined as adaptability, capacity for sublimation, and capacity to keep up relationships. A patient may desire to get well, but be so dominated by his symptom that he cannot cooperate. This is found frequently in cases of severe phobia; for example, agoraphobia, where the individual cannot go for his interviews. In such cases, the individual is best treated in a hospital. It is necessary to ascertain what the patient expects from his therapy, and his idea of his normal self. Most come with the attitude that the therapist is going to wave a magic wand and remove all problems without disturbing their general life situation. They must understand that their symptoms are an end result, a form of protest against their situations in life, and frequently sweeping changes are necessary to clear up the disturbing abnormalities. The most hopeful cases are those who come voluntarily, rather than those who are persuaded to come by their physician or their relatives. The former are usually ready to make the changes necessary.

The technic of brief psychotherapy can be divided roughly into six steps: *First,* the intellectual clarification of issues, particularly concerning sex and religion. It is sometimes advisable to see the partner. We may be dealing with the comparatively normal individual who has a frigid partner and feels that there is something wrong with him because of his inability to satisfy his mate.

Second: Advice and guidance. This entails often the management of the life situation and environment. An individual may be attempting more than his intelligence, social background, and ability allow. In such cases, we deal directly with the situation, as also, where the individual is trying to adjust to an impossible environment. Certain types of competition, economic, social or intellectual, may bring out latent symptoms which disappear when the competition is removed. A student, because of the insistence of his parents, may be attempting college when he should be a mechanic. A girl may be trying for the opera when she would make a good secretary. Age, racial background, traditions, childhood conditioning, social status, financial status, and intelligence are important factors. Obstacles encountered are the amount of gain through the illness and difficulties in solving environmental problems. It is sometimes necessary to take a definite stand, particularly on moral issues, where enlightenment and reassurance are not sufficient. To do so, we require a positive transference. The patient must be made to take action and not remain passive. His aggressiveness must be stimulated, if necessary, as a means of self defense and self preservation. The moment he does something definite about his situation, he will begin to respond and half the battle is won.

Three: Catharsis. Many patients respond (through an unburdening of problems) to an understanding and sympathetic listener. Catharsis is, of course, present to a greater or

* Talk delivered by invitation September 13, 1946, to participants in the course in neuropsychiatry sponsored jointly by the N. J. Neuropsychiatric Association and Extension Division, Rutgers University.

less degree in all types of therapy, but in some cases, it is of paramount importance; for example, the housewife whose husband is always too busy to listen to her problems and difficulties, and who is compelled to keep them to herself throughout the years; or the clerk who works for a domineering and unsympathetic boss.

Four: Interpretation of transference and resistance. A positive transference is necessary to obtain results and to give the patient the courage to make the changes necessary in his situation. However, such a transference, which may occasionally become embarrassingly strong, should be distinctly understood by the patient. He should not be allowed to become too dependent on the therapist and should understand that positive feelings have nothing to do with love. Positive transference should be discussed frankly and thoroughly whenever the occasion arises. This is just as true of negative transference or resistance. Whenever painful problems or the necessity for making changes come up, resistance will be there. The reason behind the resistance must be thoroughly exposed and understood before progress can be expected.

Five: Prolonged supportive therapy without creating personality changes. This has to do mostly with patients with limited prognostic outlooks who cannot make any dramatic changes in their life situations. We merely try to keep them functioning in their environment and in their work, through continued visits and the support they receive from the therapist by way of encouragement, explanation, and direction. These people must be looked upon very much as the diabetic who has to take his insulin, or the epileptic who is burdened throughout life with his pills of phenobarbital and dilantin.

Six: The attitude of the therapist. The therapist responds to conscientious effort, good sportsmanship, and the development of insight in the individual warmly and cordially. He fails to respond to harmful and defensive characteristics. He does not become a part of the patient's neurosis. He does not allow the patient to change the doctor's point of view, merely because the patient wishes to gain an end, or to refrain from making the changes within himself or the environment that are necessary. But we cannot go faster than the patient can tolerate. To try to do so merely creates anxiety and matters discussed are not assimilated. It is necessary during the first sessions to give some measure of hope and understanding and we expect some response within the first few sessions or the outlook is unfavorable.

Patients too sick or too well for analysis are treated by brief psychotherapy. Anyone who is accessible can be so treated. Patients fall, roughly, into two groups—*first, acute disturbances*: (a) Those who were previously well adjusted, and (b) Chronically ill persons who have had an acute exacerbation. And, *second, the chonic cases.*

RESULTS

Where the individual has had a previous good adjustment, a good ego strength, insight, and the ability for rapport with the therapist, the outlook is favorable. Where the individual can make use of the interpretations and apply them, he will do well. Where the ego is weak, outlook is poor. Situational difficulties respond best. Reactive depressions are favorable. Psychoneuroses, in general, respond well where the ego is strong. Schizophrenics may do better with brief psychotherapy than with analysis, as they cannot stand the passivity in analysis. It creates too much anxiety. Some psychopathic personalities respond well enough to be analyzed later. Sexual perversion has an unfavorable outlook. In dealing with the exacerbations of a chronic neurosis, we expect merely to get them back to their neurotic defenses. Psychosomatic patients have about a fifty per cent chance, depending on the individual himself, his ego strength, and the type of illness. Accident-prone individuals are difficult to treat because of very deeply seated and defective attributes of judgment which require great patience and time in discovery and eradication. Acute psychotics are not accessible and do not respond.

New Jersey State Hospital
Marlboro, New Jersey

RAMSEY HUNT SYNDROME WITH THORACIC HERPES
(WITHOUT AURICULAR ERUPTION)

William A. Leff,* M.D., South Orange, N.J.

Geniculate ganglionitis has been known as the Ramsey Hunt syndrome since it was first described [1] in 1907. The case here reported is the first one recorded in the American literature presenting all the manifestations of geniculate ganglionitis along with herpes zoster of the seventh, eighth, ninth and tenth thoracic dermatomes. It also merits reporting because the patient exhibited all the clinical findings of the Ramsey Hunt syndrome without zoster involvement in the distribution of the sensory fibers.

As originally described by Ramsey Hunt,[1] the syndrome was a combination of paralysis of the facial nerve, auricular herpes, tinnitus, vertigo, and (sometimes) deafness, all the symptoms being ascribed to an herpetic lesion of the geniculate ganglion. The herpetic eruption is found in and around the external auditory meatus on the same side. Vesicles may also be present on the pillars of the fauces and on the anterior two thirds of the tongue on that side.

Is the geniculate ganglion actually invaded by the zoster virus? This has been answered by Aitken and Brain.[2] They report nine cases of Bell's palsy with zoster-like eruptions in the areas of sensory supply of the geniculate ganglion, and found that the sera contained antibodies to zoster virus, demonstrable by compliment fixation tests. This serologic evidence supported Hunt's clinical explanation that such cases were due to specific zoster infection of the geniculate ganglion.

Herpes zoster often affects a particular segment with weakness or paralysis of the corresponding muscle. Thus, Wilson [7] had a patient with zoster of the fourth cervical segment and weakness of the deltoid and biceps. He pointed out that in any segment, either all or a few or just one of the muscles might be affected. Taylor's patient [3] had right abdominal zoster with paralysis of the recti and obliques. Rocchi's case [4] of zoster affected the twelfth thoracic and first lumbar segments with weakness of the corresponding obliques. Many similar cases are cited by Wilson.[7]

The clinical manifestations [5] of the Ramsey Hunt syndrome (geniculate ganglionitis) were accepted without question for many years though both Spillane [6] and Wilson [7] have shown that gasserian and geniculate ganglionitis and facial palsy can occur without auricular, palatal or postauricular eruption. The absence of auricular herpes is especially interesting. It indicates that herpetic invasion of the geniculate ganglion can take place without any cutaneous manifestations in the distribution of its sensory fibers.

Taterka and O'Sullivan [8] pointed out that in spinal herpes zoster, atrophic pareses do not necessarily coincide with the cutaneous eruption in segmental localization and extension. They presented Joffroy's case in which a zoster eruption of the right shoulder was followed by pareses of the adductor pollicis, the interossei, and the hypothenar muscles of the same extremity. Parry and Laszlo [9] likewise described a male of thirty-three who had spinal herpes zoster of the chest and double vision paresis of the right sixth cranial nerve. This is strong evidence against the previous assumption that herpetic vesiculation of the auricle (with or without periaural or juxtaaural eruption within the adjoining gasserian and cervical dermatomes) arises from the same ganglionic involvement.

Denny-Brown, Adams and Fitzpatrick [10] have shown that the evidence for geniculate

* Dr. Leff is chief resident in medicine, Fourth Division, Bellevue Hospital. This paper comes from that Division, Charles Nammack, M.D., director.

1. Hunt, Ramsey: Journ. Nerv. and Mental Dis., 34:703, (1907.)
2. Aitken, R. S., and Brain, R. T.: Lancet, 224:18, (1933.)
3. Taylor, F.: Guy's Hosp. Rep., 52:37, (1895.)
4. Rocchi, F.: Rev. Neurol., 11:368, (1938.)
5. Hunt, Ramsey: Brain, 38:418, (1915.)
6. Spillane, J. D.: Brit. Med. Journ., 1:236, (1941.)
7. Wilson, J. A. K.: *Neurology* Baltimore. Williams and Wilkins, Vol. 1, page 678, (1940.)
8. Taterka, J. H., and O'Sullivan, Mary E.: Journ. Am. Med. Ass'n., 122:737, (1943.)
9. Parry, T. G., and Laszlo, G. C.: Brit. Journ. Opth., 27:465, (1943.)
10. Denny-Brown, Adams, R. D., Fitzpatrick, P. J.: Arch. Neurology and Psychiatry, 51:216, (1944.)

ganglionitis in Ramsey Hunt syndrome is invalid. They find that herpes zoster syndromes with palsy of the facial nerve depend on concurrent involvement of two or more cranial nerves. O'Neill's splendid paper[11] on the Ramsey Hunt syndrome contains a wealth of information on the anatomy, physiology, and neuropathology of the subject. It is his opinion that "the geniculate ganglion as any cranial sensory ganglion is involved, but that such involvement constantly produces otalgia and aural herpes zoster with and without facial paralysis is not in accordance with observed clinical data. Further to acclaim that all aural, circumoral and juxta-aural herpes lies in the domain of the geniculate ganglion is to proclaim an unproved assertion, nor has Hunt produced any satisfactory necropsy evidence to support his thesis".

CASE REPORT

Chief Complaint: Painful chest rash for five days; inflamed left eye for one day; and left facial paralysis for two days.

Present Illness: Five days ago the patient noticed a slight erythema along the right lower chest wall in the direction of the umbilicus which became painful in the ensuing five days and formed small blisters on a red base. For the past two days the pain assumed a burning character. He noticed a slight numbness on the left side of his face three days after onset of the chest erythema and could not close his left eye nor open the left side of his mouth. At the same time his left ear became sensitive to noise. Any sound above the spoken voice was painful.

Past History: Relevant only in respect to a chancre which he contacted in 1921 and for which he received inadequate treatment.

Physical Findings: He was a well nourished male of 44, complaining of burning pain along his right chest wall and upper portion of the right abdomen. Examination was negative except for the neurologic and skin findings.

Skin: Extending from the right anterior axillary line in the zone of the seventh, eighth, ninth and tenth thoracic dermatomes, to the right upper quadrant of the abdomen there was a cluster of vesicles on an erythematous base, many of which had fused to form small bullae.

Neurological Examination: Sense of smell was intact. External ocular movements were well performed, except for very slight bilateral nystagmus. There was diminution of pain sensation over the left face in all three divisions of the fifth nerve. This was more marked in the upper face. Left corneal reflex was absent. He exhibited a complete left facial palsy and loss of taste over the anterior two-thirds of the left side of the tongue. Hearing was moderately diminished in the left ear. A vesicular eruption was seen on the left anterior faucial pillar. Gag reflex from the left anterior pharynx was greatly diminished. Sensation was diminished in external auditory canal of left ear. The tongue, sternomastoids and trapezii were normal.

Sensation to pin-prick diminished over dermatomes 7, 8, 9 and 10 in the region of the rash (right side). Tendon reflexes were normal, but the right upper abdominal was absent. No asynergia, adiadokakinesia or tremors were elicited.

Laboratory Findings: Urine analyses were repeatedly negative. The white cell count was 10,450. Hemoglobin was 100 per cent. Blood Wassermann was negative. The nonprotein nitrogen content of the blood was 32 milligrammes and sugar 71 milligrammes per hundred cubic centimeters.

Spinal Fluid was clear. No cells were present. In milligrammes per hundred cubic centimeter, the protein was 43, the chloride 735 and the sugar 59. The colloidal gold curve was 0000000000. Initial pressure was fourteen centimeters (of water) and final pressure was seven centimeters. Queckenstedt test was normal.

Electrocardiogram: A sinus arrhythmia with a P-R interval of 0.22 seconds was found.

Course: The patient complained of a slight degree of burning pain in the region of the rash for the first four days, after which the vesicles started to dry. They gave him no further trouble. On the fifth day he complained of "buzzing" in the left ear and had a feeling of "pins and needles" over the left side of his face; this cleared up in the ensuing three days. On the seventh day he complained of dizziness everytime he arose from the bed; this also cleared up in the next two days. The remainder of his hospital stay was uneventful and the patient signed out on the fourteenth day, completely symptomless except for the left facial palsy which had improved only to the extent that he could barely close the left eye. Nor did any of the other cranial nerve involvement show improvement from the day of admission, except for the impaired hearing which had cleared up entirely.



Note the herpes of the seventh to tenth thoracic dermatomes on the right and the Bell's palsy on the left.

Follow-Up: The patient was seen 90 days after he left the hospital. At that time he was free of all symptoms and had no signs of his illness. An electrocardiogram showed a P-R interval of 0.20 seconds. At the site of the herpes zoster, a few pigmented areas were still visible.

11. O'Neill, H.: Arch. Otolaryngology, 42:309, (1945.)

SUMMARY

This is the report of a 44-year-old man with herpes zoster of the right chest wall showing the Ramsey Hunt syndrome: namely, left facial palsy, slight bilateral nystagmus, diminution of pain sensation over the left side of the face in all three divisions, absent left corneal reflex, loss of taste over two-thirds of left side of the tongue, moderate diminution of hearing in left ear, vesicular eruption of the left anterior faucial pillar, diminution of gag reflex from left anterior pharynx, and diminished sensation in the external auditory canal of the left ear. These clinical findings confirm the current opinion that the Ramsey Hunt syndrome is not a manifestation of a geniculate ganglionitis alone but rather that it is a concurrent involvement of several cranial nerves. It likewise supports the premise that the syndrome can exist without zoster involvement of the sensory fibers of the geniculate ganglion.

321 Wyoming Avenue

PHYSICIANS POST ORGANIZED

Announcement is made of the formation of a Physicians Post (445) of the American Legion. This is the only veterans' organization in New Jersey limited exclusively to members of the medical profession and one of the few such units in the country. Formal institution of the post is planned for September 27, 1947. More than 200 physicians have already joined the Post and all who are enrolled prior to September 27, 1947, will be considered Charter Members. Membership is open to any American physician, regardless of race, creed or color, who had active duty in the Army, Navy or Public Health Service during either war, and who was honorably separated from the service. Temporary officers of the Post, most of whom are members of The Medical Society of New Jersey are:

Commander, Ulysses M. Frank; *senior vice-commander,* Joseph E. Higi; *junior vice-commander,* Joseph A. Santangelo; *historian,* William S. Schram; *financial officer,* Victor Di Leo; *adjutant,* August Belott; *judge advocate,* Henry A. Brodkin; *welfare officer,* Asher Yaguda; *chaplain,* William J. Sweeley; and *sergeant-at-arms,* Robert M. Waldron.

PENICILLIN IN CONGENITAL SYPHILIS

Yampolsky and Heyman, at Emory University School of Medicine in Atlanta, used penicillin to treat 61 syphilitic children, according to the October 19 *Journal of the American Medical Association.*

Thirty-two of the 61 children had simple infantile congenital syphilis. Twenty-three of the 32 responded satisfactorily under the penicillin treatment. "All 23 are clinically well, have normal spinal fluids and exhibit no clinical evidence of the disease."

While three of the patients died, the authors believe that the fatalities were in no way related to the treatment. Two of the deaths "apparently resulted from an overwhelming syphilitic infection in premature and malnourished infants, while the third fatality remains unexplained."

In discussing the remaining 29 patients, the authors say that seven were suffering from acquired primary and secondary syphilis, while the others were treated for late forms of congenital syphilis.

In the seven cases of acquired syphilis, the patients were treated with doses of penicillin comparable to those used in adults. "The syphilitic lesions healed promptly in every case and the spirochetes disappeared rapidly."

"Results obtained with penicillin in the treatment of syphilis in children depend on the nature and duration of the disease. Although penicillin appears effective in infantile congenital syphilis and in early neurosyphilis, little response can be expected in treatment of the manifestations of this disease."

Yampolsky and Heyman say that while the optimum dosage cannot be determined in such a small series of cases, "we believe that a total dose of penicillin of 100,000 units per kilogram of body weight is effective in the treatment of the majority of these cases."

WORKMEN'S COMPENSATION AND THE GENERAL PRACTITIONER *

Compiled by the Advisory Committee on Workmen's Compensation of The Medical Society of New Jersey, 1946-1947

W. K. HARRYMAN, M.D., Chairman

Those of us who see many compensation cases have observed that the average general practitioner has little real concept of many of the salient points in the Workmen's Compensation Laws of our state. This is detrimental to his own interest and to that of his patients. It is also often unfair to the insurance carrier who must have accurate records upon which to base an estimate of reserves set up to take care of possible medical expenses. Our Committee, therefore, feels that a perusal of the following will clarify many of the more important points and thereby assist our fellow practitioners.

POINTS TO REMEMBER IN TREATING ALL COMPENSATION CASES

1. You have three parties to consider—your patient, the insurance carrier, and yourself.

2. Treat all compensation cases as thoroughly and as courteously as your private patients. Make each patient feel that you are taking a real and personal interest in him. Unless you first obtain your compensation patient's confidence you will get poor results and possible later criticism. Let an antagonistic patient go to another physician for further treatment rather than try to hold him under these conditions.

3. The carrier pays the bills and represents the employer. He must have prompt and accurate records in order that he may put aside proper reserves. He cannot pay the injured party unless he has the necessary reports and knows the prognosis. Give full details in each report and if complications arise or consultants are needed later, advise the carrier at once. Make fair charges for the services rendered. The carrier expects to pay fair charges, but will contest excessive amounts. If these suggestions are followed, the carrier will have a good picture of the case in his files, and there will be few arguments over bills. In such disputes the doctor himself is often at fault in that he has not kept the insurance company aware of the unusual or unexperienced developments, or he has not fully explained large bills. Do your share—the rest is up to the carrier. You will find him helpful, cooperative and appreciative.

4. Give the best treatment you can and you will benefit by added experience and the satisfaction of aiding in a good recovery. Make friends of your patients and of the carrier. Both will reciprocate and as a result, your practice and your income will increase.

EXCERPTS FROM THE LAW

The Workmen's Compensation Law comes under the classification of "Remedial Legislation". This means that its provisions are liberally construed. The provisions of the law were created in order that a greater number might obtain the benefits of its protection than was possible before the law was passed.

TEMPORARY DISABILITY

35:15-12. Schedule of payments. Temporary disability. a. For injury producing temporary disability, sixty-six and two-thirds per cent of the wages received at the time of the injury, subject to a maximum compensation of twenty-five dollars per week and a minimum of ten dollars per week. This compensation shall be paid during the period of such disability, not, however, beyond three hundred weeks.

TOTAL PERMANENT DISABILITY

Permanent total disability. b. For disability total in character and permanent in quality, sixty-six and two-thirds per cent of the wages received at the time of injury, subject to a maximum compensation of twenty-five dollars per week and a minimum of ten dollars per week. This compensation shall be paid for a period of four hundred and fifty weeks at which time compensation payments shall cease unless the employee shall have submitted to such physical or educational rehabilitation as may have been ordered by the rehabilitation commission, and can show that because of such disability it is impossible for him to obtain wages or earnings equal to those earned at the time of the accident, in which case further weekly payments shall be made during the period of such disability, the amount thereof to be the previous weekly compensation payment diminished by that portion thereof that the wage, or earnings, he is then able to earn, bears to the wages received at the time of the accident. If his wages or earnings equal or exceed wages received at time of accident, then his compensation rate shall be reduced to five dollars. In calculating compensation for the extension beyond four hundred and fifty weeks the minimum provision of ten dollars shall not apply. This extension of com-

* With acknowledgment and thanks to Daniel A. Spair, Esq., Director, Workmen s Compensation Bureau, who has reviewed and corrected this report.

pensation payments beyond four hundred and fifty weeks shall be subject to such periodic reconsiderations and extensions as the case may require, and shall apply only to disability total in character and permanent in quality, and shall not apply to any accident occurring prior to July fourth, nineteen hundred and twenty-three.

Total disability is 450 weeks. Where partial-total disability presents itself, the quotient used under the law is 550 weeks, so that it is possible for a man to be, let us say, 90 per cent partially-totally disabled, which would entitle him to more weeks' compensation than if he were totally disabled. This is readily understood when one knows that there is an agency set up under the workmen's compensation law whereby when a man is totally disabled and he cannot be rehabilitated that he can petition for compensation for life. This would not apply to the man who was partially-totally disabled, which implies that he still had some earning capacity.

PARTIAL PERMANENT DISABILITY

34:15-12. c. For disability partial in character, but permanent in quality, the compensation shall be based upon the extent of such disability. In cases included in the following schedule the compensation shall be that named in the schedule, to wit:

Thumb. d. For the loss of the thumb, sixty-six and two-thirds per cent of daily wages during seventy-five weeks.

First finger. e. For the loss of the first finger, commonly called index finger, sixty-six and two-thirds per cent of daily wages during fifty weeks.

Second finger. f. For the loss of a second finger, sixty-six and two-thirds per cent of daily wages during forty weeks.

Third finger. g. For the loss of a third finger, sixty-six and two-thirds per cent of daily wages during thirty weeks.

Fourth finger. h. For the loss of a fourth finger, commonly called little finger, sixty-six and two-thirds per cent of daily wages during twenty weeks.

Phalange. i. The loss of the first phalange of the thumb or of any finger shall be considered to be equal to the loss of one-half of such thumb or finger and the compensation shall be for one-half of the periods of time above specified. The loss of any portion of the thumb or any finger between the terminal joint and the end thereof shall be compensated for a like proportion of the period of time prescribed for the loss of the first phalange of such member.

More than one phalange. j. The loss of the first phalange and any portion of the second shall be considered as the loss of the entire finger or thumb, but in no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand.

Great toe. i. For the loss of a great toe, sixty-six and two-thirds per cent of daily wages during forty weeks.

Other toes. l. For the loss of one of the toes other than a great toe, sixty-six and two-thirds per cent of daily wages during fifteen weeks.

Phalange of toe. m. The loss of the first phalange of any toe shall be considered to be equal to the loss of one-half of such toe, and compensation shall be for one-half of the period of time above specified.

More than one phalange. n. The loss of the first phalange and any portion of the second shall be considered as the loss of the entire toe.

Hand. o. For the loss of a hand, or of the thumb and the first and second fingers (on one hand) or of four fingers (on one hand), sixty-six and two-thirds per cent of the daily wages during two hundred and thirty weeks.

Under the law, the hand extends from the elbow down, but does not include the elbow. If there is involvement of the elbow or above, this is regarded as the arm. The loss of an arm entitles the man to 300 weeks.

Arm. p. For the loss of an arm, sixty-six and two-thirds per cent of daily wages during three hundred weeks.

Foot.† *q.* For the loss of a foot, sixty-six and two-thirds per cent of daily wages during two hundred weeks.

Leg. r. For the loss of a leg, sixty-six and two-thirds per cent of daily wages during two hundred and seventy-five weeks.

Vision. s. For the loss of vision of an eye, sixty-six and two-thirds per cent of daily wages during one hundred and fifty weeks.

Eye. ss. For the enucleation of an eye twenty-five weeks in addition to such compensation as may be allowed under section (s).

Tooth. t. For the loss of a natural tooth, sixty-six and two-thirds per cent of daily wages for four weeks for each tooth lost.

Hearing. u. For the total loss of hearing in one ear, sixty-six and two-thirds per cent of daily wages during sixty weeks. For the total loss of hearing in both ears by one accident, sixty-six and two-thirds per cent of daily wages during two hundred weeks.

Two members. v. The loss of both hands, or both arms, or both feet, or both legs, or both eyes, or any two thereof as a result of any one accident, shall constitute total and permanent disability to be compensated according to the provisions of paragraph "b".

Amputation. vv. Amputation between the elbow and the wrist shall be considered as the equivalent of the loss of a hand and amputation at the elbow shall be considered as the equivalent to the loss of the arm. Amputation between the knee and

† The foot (from the knee down) entitles the man to 200 weeks. The leg extends from outside the hip joint to the tips of the toes and rates 275 weeks.

ankle shall be considered as the equivalent of the loss of a foot, and amputation at the knee shall be considered equivalent to the loss of the leg.

Injuries to parts of the body such as a kidney, the spine, the skull, the nervous system, etc., are "non-schedule", but are evaluated in terms of total or partial-total disability.

Other cases. w. In all lesser or other cases involving permanent loss, or where the usefulness of a member or any physical function is permanently impaired, the compensation shall be sixty-six and two-thirds per cent of daily wages, and the duration of compensation shall bear such relation to the specific periods of time stated in the above schedule as the disabilities bear to those produced by the injuries named in the schedule. In cases in which the disability is determined as a percentage of total and permanent disability the duration of the compensation shall be a corresponding portion of five hundred and fifty weeks. Should the employer and employee be unable to agree upon the amount of compensation to be paid in cases not covered by the schedule, either party may appeal to the workmen's compensation bureau for a settlement of the controversy.

The difficulty that doctors encounter is not in reference to clear-cut cases of schedule loss. When function is affected, the matter of individual evaluation comes into play. This phase of the work calls for individual experience, usually based on experience in similar cases. It entails a good bit of thought on the part of the doctor and the aptitude of the doctor in this respect is only as good as the time and effort he is willing to put to the work.

A good rule to apply where one concerns himself with the partial loss of use of a member, or the body as a whole, is to imagine himself surveying the case through a telescope, envisioning the picture as a whole, and then comparing that with what he regards to be the average normal. This is most important because the law does not concern itself with the work that the man might have been performing at the time he was hurt, but rather wishes to think of the person as an average normal unit.

HERNIA

Hernia. x. Inguinal hernia is a disease which ordinarily develops gradually, being very rarely the result of an accident. Where there is a real traumatic hernia resulting from the application of force directly to the abdominal wall, either puncturing or tearing the wall, compensation will be allowed. All other cases will be considered as either congenital or of slow development and not compensable, being a disease rather than an accident injury; unless preponderant proof is offered that the hernia was immediately caused by such sudden effort or severe strain that, first, the descent of the hernia immediately followed the cause; second, that there was a severe pain in the hernial region; third, that there was such prostration that the employee was compelled to cease work immediately; fourth, that the above facts were of such severity that the same was noticed by the claimant and communicated to the employer within twenty-four hours after the occurrence of the hernia (days when the business is not in operation, such as Sundays, Saturdays or holidays shall be excluded from this twenty-four hour period); fifth, that there was such physical distress that the attendance of a licensed physician was required within twenty-four hours after the occurrence of the hernia. In the case of hernia as above defined, the provisions of paragraph "a" of this section and sections 34:15-14 and 34:15-15 of this title shall apply, until such time as the employee is able to resume some kind of work with the aid of a truss or other mechanical appliance. If the employee refuses to permit of an operation the employer shall meet the requirements above specified, pay the reasonable costs of the truss or other appliance found necessary, and also pay compensation for twenty weeks, following which the obligation shall cease and terminate, unless death results from the hernia, in which case the provisions of section 34:15-13 of this title shall apply. However, if the employee shall elect to undergo an operation, by a physician selected by the employer, the employer shall meet all the expense incident to such operation and recovery, together with compensation as provided in paragraph "a" of this section during the periods of disability prior to and following the operation, subject to the provisions of said section 34:15-14. If the employee refuses the services of the physician selected by the employer, preferring one of his own selection, the employer shall be relieved of obligations concerning medical expense due to the operation and recovery, but shall pay compensation during the prior and resulting periods of disability. If death results from the hernia or operation, the provisions of said section 34:15-13 shall apply.

WAITING PERIOD

34:15-14. No compensation other than medical aid shall accrue and be payable until the employee has been disabled seven days, whether the days of disability immediately follow the accident or whether they be consecutive or not. These days shall be termed the waiting period. The day that the employee is unable to continue at work by reason of his accident, whether it be the day of the accident or later, shall count as one whole day of the waiting period. Should the total period of disability extend beyond four weeks, additional compensation shall at once become payable covering the above prescribed waiting period.

MEDICAL SERVICE

34:15-15. The employer shall furnish to the injured workman such medical, surgical and other treatment, and hospital service as shall be necessary to cure and relieve the workman of the ef-

fects of the injury and to restore the functions of the injured member or organ where such restoration is possible; provided, however, that the employer shall not be liable to furnish or pay for physicians' or surgeons' services in excess of fifty dollars and in addition to furnish hospital service in excess of fifty dollars, unless the injured workman or the physician who treats him, or any other person on his behalf, shall file a petition with the Workmen's Compensation Bureau stating the need for physicians' or surgeons' services in excess of fifty dollars, as aforesaid, and such hospital service of appliances in excess of fifty dollars, as aforesald, and the Workmen's Compensation Bureau after investigating the need of the same and giving the employer an opportunity to be heard, shall determine that such physicians' and surgeons' treatment and hospital services are or were necessary, and that the fees for the same are reasonable and shall make an order requiring the employer to pay for or furnish the same.

If the employer shall refuse or neglect to comply with the foregoing provisions of this section the employee may secure such treatment and services as may be necessary and as may come within the terms of this section, and the employer shall be liable to pay therefor; provided, however, that the employer shall not be liable for any amount expended by the employee or by any third person on his behalf for any such physicians' treatment and hospital services, unless such employee or any person on his behalf shall have requested the employer to furnish the same and the employer shall have refused or neglected so to do, or unless the nature of the injury required such services, and the employer or his superintendent or foreman, having knowledge of such injury shall have neglected to provide the same, or unless the injury occurred under such conditions as make impossible the notification of the employer, or unless the circumstances are so peculiar as shall justify, in the opinion of the Workmen's Compensation Bureau, the expenditure assumed by the employee for such physicians' treatment and hospital services, apparatus and appliances.

MEDICAL FEES

All fees and other charges for such physicians' and surgeons' treatment and hospital treatment should be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services.

PROSTHESIS

When an injured employee may be partly or wholly relieved of the effects of a permanent injury, by use of an artificial limb or other appliance, which phrase includes artificial teeth or glass eye, the Workmen's Compensation Bureau, acting under competent medical advice, is empowered to determine the character and nature of the limb or appliance, and to require the employer or his insurance carrier to furnish it.

NOTICE TO EMPLOYER

34:15-17. Unless the employer shall have actual knowledge of the occurrence of the injury, or unless the employee, or someone on his behalf, or some of the dependents, or someone on their behalf shall give notice thereof to the employer within fourteen days of the occurrence of the injury, then no compensation shall be due until such notice is given or knowledge obtained. If the notice is given, or the knowledge obtained within thirty days from the occurrence of the injury, no want, failure, or inaccuracy of a notice shall be a bar to obtaining compensation, unless the employer shall show that he was prejudiced by such want, defect or inaccuracy, and then only to the extent of such prejudice. If the notice is given, or the knowledge obtained within ninety days, and if the employee, or other beneficiary, shall show that his failure to give prior notice was due to his mistake, inadvertence, ignorance of fact or law, or inability, or to the fraud, misrepresentation or deceit of another person, or to any other reasonable cause or excuse, then compensation may be allowed, unless, and then to the extent only that the employer shall show that he was prejudiced by failure to receive such notice. Unless knowledge be obtained, or notice given, within ninety days after the occurrence of the injury, no compensation shall be allowed.

EXAMINATIONS

34:15-19. After an injury, the employee, if so requested by his employer, must submit himself for physical examination and x-ray at some reasonable time and place within this State, and as often as may be reasonably requested, to a physician or physicians authorized to practice under the laws of this State. If the employee requests, he shall be entitled to have a physician or physicians of his own selection present to participate in such examination. The refusal of the employee to submit to such examination shall deprive him of the right to compensation during the continuance of such refusal. When a right to compensation is thus suspended no compensation shall be payable in respect of the period of suspension. On request, the Workmen's Compensation Bureau may examine the x-ray for the purpose of determining the amount of disability due, if any.

REFUSAL BY EMPLOYEE

34:15-23. Whenever it shall appear that an employer is being prejudiced by virtue of the refusal of an injured employee to accept proffered medical and surgical treatment deemed necessary by the physician selected by the employer, or his failure or neglect to comply with the instructions of the physicians in charge of the case, the employer is hereby authorized to file a petition with the Workmen's Compensation Bureau, which is hereby empowered to order proper medical and surgical treatment at the expense of the employer. In the event of refusal or neglect by the employee to comply with this order the bureau shall make such modification in the award contained in the schedule as the evidence produced shall justify.

OCCUPATIONAL DISEASES

34:15-31. a. Compensable occupational diseases shall not include any other than those scheduled below and shall include those so scheduled only when the exposure stated in connection therewith has occurred during the employment, and the disability has commenced within five months after the termination of the exposure.

Occupational diseases: (1) anthrax; (2) lead poisoning; (3) mercury poisoning; (4) arsenic poisoning; (5) phosphorus poisoning; (6) poisoning from benzene and its homologues, and all derivatives thereof; (7) wood alcohol poisoning; (8) chrome poisoning; (9) caisson disease; (10) mesothorium or radium poisoning; (11) dermatitis venenata.

34:15-33. Unless the employer during the continuance of the employment shall have actual knowledge that the employee has contracted a compensable occupational disease, or unless the employee or someone on his behalf, or some of his dependents, or someone on their behalf, shall give the employer written notice or claim that the employer has contracted one of the compensable occupational diseases which notice to be effective must be given within a period of five months after the date when the employee shall have ceased to be subject to exposure to the occupational disease, no compensation shall be payable on account of the death or disability by occupational disease of the employee.

34:15-31. b. Willful self-exposure to occupational diseases shall include:

1. Failure or omission to observe such rules and regulations as may be promulgated by the Department of Labor and posted in the plant by the employer, tending to the prevention of occupational diseases.

2. Failure or omission to truthfully state to the best of the employee's knowledge, in answer to inquiry made by the employer, the location, duration and nature of previous employment of the employee in which he was exposed to any occupational disease as herein listed.

By virtue of supplement to the Workmen's Compensation Law, (Chapter 88, Laws of 1944) effective January 1, 1945, silicosis and asbestosis are made compensable occupational diseases under the Workmen's Compensation Act, but it must be noted that the provisions of the supplement are different from the provisions of the Workmen's Compensation Law applying to the other compensable occupational diseases listed above.

THIRD PARTY LIABILITY

34:15-40. Where a third person or corporation is liable to the employee or his dependents for an injury or death, the existence of a right of compensation from the employer or insurance carrier under this statute shall not operate as a bar to the action of the employee or his dependents, nor be regarded as establishing a measure of damage therein. In the event that the employee or his dependents shall recover and be paid from the said third person or corporation, any sum in release or in judgement on account of his or its liability to the injured employee, the liability of the employer under this statute thereupon shall be only such as is hereinafter in this section provided.

(a) The obligation of the employer or his insurance carrier under this statute to make compensation payments shall continue until the payment, if any, by such third person or corporation is made.

(b) If the sum recovered by the employee from the third person or corporation, after the expenses of suit and attorney's fee or either of them, as hereinafter defined, have been deducted therefrom, is equivalent to or greater than the liability of the employer or his insurance carrier under this statute, the employer or his insurance carrier shall be released from such liability and shall be entitled to be reimbursed as hereinafter provided, for the medical expenses incurred and compensation payments theretofore paid to the injured employee or his dependents.

(c) If the sum recovered by the employee as aforesaid, after the expenses of suit and attorney's fee, or either of them, as hereinafter defined, have been deducted therefrom, is less than the liability of the employer or his insurance carrier under this statute, the employer or his insurance carrier shall be liable only for the difference and shall be entitled to be reimbursed, as hereinafter provided for so much of the medical expenses incurred and compensation payments theretofore paid to the injured employee or his dependents as exceeds the amount of such difference.

(d) If at any time prior to the payment by the third person or corporation to the injured employee or his dependents, the employer or his insurance carrier shall serve notice, as hereinafter provided, upon such third person or corporation that compensation has been applied for by the injured employee or his dependents it shall thereupon become the duty of such third person or corporation, before making any payment to the injured employee or his dependents, to inquire from such employer or his insurance carrier the amount of medical expenses incurred and compensation theretofore paid to the injured employee or to his dependents. Where such notice shall have been served, it shall further become the duty of such third person or corporation, before making any payment as aforesaid, to inquire from such injured employee or his dependents the amount of the expenses of suit and attorney's fee, or either of them in the action or settlement of the claim against such third person or corporation. Thereafter, out of that part of any amount about to be paid in release or in judgment by such third person or corporation on account of his or its liability to the injured employee remaining after deducting the employee's expenses of suit and attorney's fee, as hereinafter defined, the employer or his insurance carrier shall be entitled to receive from such third person or corporation, a sum equivalent to the medical expenses incurred and the compensation paid theretofore by the employer or his insurance carrier to the injured employee or his dependents, or so much thereof as may be due the employer or insurance carrier pur-

suant to subparagraph (c) of this section. Such sum shall be deducted by such third person or corporation from the sum to be paid in release or in judgment to the injured employee or his dependents and shall be paid by such third party or corporation to the employer or his insurance carrier. Service of notice, hereinbefore required to be made by the employer or his insurance carrier upon such third person or corporation, shall be by registered mail, return receipt and in the case of a corporation shall be mailed to the registered office of such corporation.

Section (e) defines "expenses of suit", "attorney's fee", and similar legal terms.

STATUTE OF LIMITATIONS

34:15-41. Claims barred after two years. In case of personal injury or death, all claims for compensation on account thereof shall be forever barred unless a petition is filed in duplicate with the Secretary of the Workmen's Compensation Bureau, as prescribed by section 34:15-21 of this title.

The Statute of Limitations as to the occupational diseases listed in 34:15-31 is one year. As indicated above, there is a separate supplement as to silicosis and asbestosis.

LEGAL POWERS

34:15-60. The commissioner, each deputy commissioner and each of the referees shall have the same power as the court of common pleas to issue subpoenas to compel the attendance of witnesses and the production of books and papers. The fees for the attendance of witnesses shall be such as are now provided for the attendance of witnesses in other civil cases, and shall be paid by the party arranging for the attendance of such witnesses. The subpoenas shall be authenticated by the seal of the department, and either party to any such proceeding may, without charge, secure subpoenas from the commissioner, a deputy commissioner or any referee. Misconduct on the part of any person attending a hearing, or the failure of any witness, when duly subpoenaed, to attend or give testimony shall be punishable by the commissioner, each deputy commissioner and each of the referees, in the same manner as such failure is punishable by the Court of Common Pleas in a case therein pending.

34:15-61. The commissioner, each deputy commissioner and each referee shall have power to administer oaths. Any person who, having been sworn as a witness in any such proceeding, shall willfully give false testimony shall be guilty of perjury.

34:15-64. The commissioner and the deputy commissioners may make such rules and regulations for the conduct of the hearing not inconsistent with the provisions of this chapter as may, in his judgment, be necessary. The official conducting any hearing under this chapter may, in his discretion, allow to the party in whose favor judgment is entered, costs of witness fees and a reasonable attorney fee, not exceeding twenty per cent of the judgment; and a reasonable fee not exceeding fifty dollars for any one witness, or one hundred fifty dollars in any one case, for medical witnesses residing in the state, when in his judgment the services of an attorney and medical witnesses were necessary for the proper presentation of the case. When, however, prior to any hearing compensation has been offered or paid, the reasonable allowance for attorney fee shall be based upon only that part of the judgment or award in excess of the amount of compensation theretofore offered or paid. When the amount of the judgment, or when that part of the judgment or award in excess of compensation theretofore offered or paid, is less than two hundred dollars, an attorney fee may be allowed not in excess of fifty dollars.

EXAMINATION OF FEMALES

34:15-68. In all cases where it shall be necessary to make a physical examination of a female employee in an inquiry to award compensation, the examination shall be made by a female physician if the employee so requests.

REPORTS OF ACCIDENT BY EMPLOYER AND INSURER

34:15-96. Every employer carrying insurance as required by article 5 of this chapter shall make report in accordance with the terms of his insurance policy upon the happening of any accident or the occurrence of any compensable occupational disease in his establishment. Such report shall be prepared in triplicate upon a form, designated as "first notice of accident", to be furnished by the insurance carrier. One copy shall be sent to the Department of Labor, one copy to the insurance carrier, and one copy shall be kept on file by the employer. A supplemental report shall be prepared on a form designated as "supplemental report", and sent in like manner, at the expiration of the waiting period prescribed by section 34:15-14 of this title.

If, however, the employee is able to resume work before the expiration of the waiting period, the supplemental report shall be sent immediately upon his return. Thereafter the employer shall promptly furnish the carrier the information demanded and necessary to enable it to carry out the intent of this chapter. These reports on the first notice and supplemental forms, filed with the state, must be signed by the employer and mailed by him directly to the workmen's compensation bureau, as a check on the operations of the insurance company.

34:15-97. Report by employer not carrying insurance. An employer not carrying compensation insurance shall make report of any accident or compensable occupational disease causing a disability extending beyond the waiting period or causing any permanent injury. The report shall be prepared and sent immediately upon the employers having knowledge of the disability or injury named above, and shall be made out in duplicate upon forms to be secured from the Workmen's Compensation Bureau. One copy shall be mailed to the bureau and one copy kept on file by the employer.

Within three weeks after the accident, or the

obtaining of knowledge of compensable occupational disease, the employer operating under article 2 of this chapter (34:15-7 et seq.), shall send to the bureau a second report, containing a statement of wages and an agreement to care for the case according to the terms of the compensation law. This form shall be signed by the employee as provided thereon and by the employer. Immediately upon the employee recovering so as to be able to resume work, the employer shall file with the bureau a final report, setting forth the length of disability, the nature and extent of permanent injury, if any, and the compensation payable for each. This form shall also be signed by the employer and the employee.

34:15-98. Report by insurance carrier. Every insurance carrier writing workmen's compensation insurance in this State shall make report of accident, or compensable occupational disease, as follows: Immediately upon receiving knowledge of an accident to an employee, or the contracting of a compensable occupational disease, causing a disability extending beyond the waiting period or causing any permanent injury, the company insuring the employer or such employee, shall at once make report to the Workmen's Compensation Bureau on a form prescribed by the bureau. Within three weeks after the carrier has learned of the accident or the contraction of such disease, such carrier shall send to the bureau a second report containing a statement of wages and an agreement to care for the case according to the terms of the compensation law. This report shall be signed by the employee as provided thereon and by the employer or insurance carrier. Immediately upon the carrier's learning that the employee has recovered so as to be able to resume work, the carrier shall prepare a final report, and take the steps necessary to have it signed by the employee, as provided thereon. This form shall also be signed by the employer or carrier and sent to the bureau as promptly as possible.

When an employee refuses to sign any of the required forms, that fact shall be noted on the blank at the point where the signature should be placed, and the forms filed with the bureau. These forms shall be fully prepared before presentation to the employee for his signature. It shall be unlawful to request or direct any injured employee to sign blank forms to be later filled out and filed with the bureau.

MEDICAL REPORTS

34:15-100. As a part of the necessary medical service required by the compensation law, the employer or insurance carrier shall, when directed so to do, file with the Workmen's Compensation Bureau copies of such medical certificates or reports as it may have on file.

NONCOMPLIANCE

34:15-101. Every employer, insurer or other person failing to comply with the terms of this article shall, for each offense, be liable to a penalty of not less than ten nor more than fifty dollars, the amount thereof to be determined by and paid to the Commissioner of Labor. Upon refusal to pay such fine, the same shall be recovered in an action at law by the Commissioner of Labor in the name of the State of New Jersey.

DISABILITY TABLE

Attached herewith is a Schedule of Disabilities and Compensation Rates, effective January 1, 1946, and the Committee, of course, is not responsible for any inaccuracies in the schedule.

The schedule is used in the following manner: Compute the disability in terms of the percentage of the member involved; then, from the table, calculate the number of weeks, the left-hand column representing your evaluation of the percentage disability, the numeral under the member giving the number of weeks. If the employee earned less than $10.00 a week, compute his compensation rate as ten dollars a week; otherwise, compute the rate as two-thirds of his salary, subject to a minimum of ten dollars a week and a maximum of twenty-five dollars a week.

For example, suppose you conclude that the arm is one-fourth (that is, 25 per cent) permanently disabled. Find 25% in the left-hand column; under "Arm" is the figure, 75. This means that the employee should receive two-thirds of his salary for 75 weeks. Total permanent disability of the arm (100% of the arm) represents 300 weeks. Similarly, if the compensable hearing loss represents say, one-fifth in one ear, then looking under the column labelled "Hearing: One Ear", the figure opposite 20 per cent (one-fifth) is "12", meaning two-thirds of the salary for twelve weeks. If the disability is calculated in terms of the entire body, that is, the entire functioning human unit, use the last column. Thus, if the employee is permanently disabled to the extent of thirty-three and one-third per cent, his disability is calculated by looking under the last column for the figure opposite thirty-three and one-third per cent, which is found to be 183 and one-third weeks; that is, in this case, the employee would be compensated at the rate of two-thirds of his wages for a little over three years.

The excerpts of the law as stated, apply to accidents occurring on and after January 1, 1946, and compensable occupational diseases on and after January 1, 1946.

The Schedule of Disabilities and Compensation Rates was different prior to January 1, 1946.

The section as to the waiting period, reducing it from seven weeks to four weeks, was effective April 2, 1945.

SCHEDULE OF DISABILITIES AND COMPENSATION RATES

EFFECTIVE JANUARY 1, 1946

Per Cent	Thumb, 1st & 2nd Finger or Hand 230 Wks.	Arm 300 Weeks	Thumb 75 Weeks	Fingers				Leg 275 Weeks	Foot 200 Weeks	Toes		Eye 150 Weeks	Hearing		Partial Total Based on 550 Weeks
				1st 50 Weeks	2nd 40 Weeks	3rd 30 Weeks	4th 20 Weeks			Large 40 Weeks	Other 15 Weeks		1 Ear 60 Weeks	2 Ears 200 Weeks	
1	2.3	3.	¾	½	.4	.3	.2	2¾	2.	.4	.15	1½	.6	2	5½
2½	5¾	7½	1⅞	1¼	1.	¾	½	6⅞	5	1.	⅜	3¾	1½	5	13¾
5	11½	15	3¾	2½	2.	1½	1	13¾	10	2	¾	7½	3	10	27½
7½	17¼	22½	5⅝	3¾	3.	2¼	1½	20⅝	15	3	1⅛	11¼	4½	15	41¼
10	23	30	7½	5	4	3	2	27½	20	4	1½	15	6	20	55
12½	28¾	37½	9⅜	6¼	5	3¾	2½	34⅜	25	5	1⅞	18¾	7½	25	68¾
15	34½	45	11¼	7½	6	4½	3	41¼	30	6	2¼	22½	9	30	82½
20	46	60	15	10	8	6	4	55	40	8	3	30	12	40	110
25	57½	75	18¾	12½	10	7½	5	68¾	50	10	3¾	37½	15	50	137½
30	69	90	22½	15	12	9	6	82½	60	12	4½	45	18	60	165
33⅓	76⅔	100	25	16⅔	13⅓	10	6⅔	91⅔	66⅔	13⅓	5	50	20	66⅔	183⅓
35	80½	105	26¼	17½	14	10½	7	96¼	70	14	5¼	52½	21	70	192½
40	92	120	30	20	16	12	8	110	80	16	6	60	24	80	220
45	103½	135	33¾	22½	18	13½	9	123¾	90	18	6¾	67½	27	90	247½
50	115	150	37½	25	20	15	10	137½	100	20	7½	75	30	100	275
55	126½	165	41¼	27½	22	16½	11	151¼	110	22	8¼	82½	33	110	302½
60	138	180	45	30	24	18	12	165	120	24	9	90	36	120	330
65	149½	195	48¾	32½	26	19½	13	178¾	130	26	9¾	97½	39	130	357½
66⅔	153⅓	200	50	33⅓	26⅔	20	13⅓	183⅓	133⅓	26⅔	10	100	40	133⅓	366⅔
70	161	210	52½	35	28	21	14	192½	140	28	10½	105	42	140	385
75	172½	225	56¼	37½	30	22½	15	206¼	150	30	11¼	112½	45	150	412½
80	184	240	60	40	32	24	16	220	160	32	12	120	48	160	440
85	195½	255	63¾	42½	34	25½	17	233¾	170	34	12¾	127½	51	170	467½
90	207	270	67½	45	36	27	18	247½	180	36	13½	135	54	180	495
95	218½	285	71¼	47½	38	28½	19	261¼	190	38	14¼	142½	57	190	522½
100	230	300	75	50	40	30	20	275	200	40	15	150	60	200	550

COMPENSATION RATES

Weekly Wage	1 Week	6 Days	5 Days	4 Days	3 Days	2 Days	1 Day
$37.50	25.00	21.426	17.855	14.284	10.713	7.142	3.571
37.00	24.666	21.138	17.615	14.092	10.569	7.046	3.523
36.00	24.00	20.568	17.140	13.712	10.284	6.856	3.428
35.00	23.333	19.999	16.665	13.332	9.999	6.666	3.333
34.00	22.666	19.428	16.190	12.952	9.714	6.476	3.238
33.00	22.00	18.852	15.710	12.568	9.426	6.284	3.142
32.00	21.333	18.282	15.235	12.188	9.141	6.094	3.047
31.00	20.666	17.712	14.760	11.808	8.856	5.904	2.952
30.00	20.00	17.142	14.285	11.428	8.571	5.714	2.857
29.00	19.333	16.571	13.809	11.047	8.285	5.523	2.761
28.00	18.666	15.999	13.333	10.666	7.999	5.333	2.666
27.00	18.00	15.428	12.857	10.285	7.714	5.142	2.571
26.00	17.333	14.856	12.38	9.904	7.428	4.952	2.476
25.00	16.666	14.286	11.905	9.524	7.143	4.762	2.38
24.00	16.00	13.71	11.425	9.14	6.855	4.57	2.285
23.00	15.332	13.14	10.95	8.76	6.57	4.38	2.19
22.00	14.666	12.57	10.475	8.38	6.285	4.19	2.095
21.00	14.00	12.00	10.00	8.00	6.00	4.00	2.00
20.00	13.33	11.428	9.52	7.616	5.712	3.808	1.904
19.00	12.666	10.854	9.045	7.236	5.427	3.618	1.809
18.00	12.00	10.284	8.57	6.856	5.142	3.428	1.714
17.00	11.332	9.708	8.09	6.472	4.854	3.236	1.618
16.00	10.666	9.138	7.615	6.092	4.569	3.046	1.523
15.00	10.00	8.568	7.14	5.712	4.284	2.856	1.428
.75	.50	.428	.357	.285	.214	.142	.071
.50	.333	.282	.235	.188	.141	.094	.047
.25	.166	.142	.119	.095	.071	.047	.023

STATE ACTIVITIES

E. J. ILL AWARD TO DR. O'CROWLEY

The June meeting of the Academy of Medicine of Northern New Jersey was the scene of the presentation of the Edward J. Ill Award to Dr. Clarence R. O'Crowley. Ceremonies were opened with the following introductory talk by the president of the Academy, Dr. Joseph I. Echikson:

The Academy of Medicine of Northern New Jersey was organized primarily to provide educational facilities for the medical profession. We have, however, entered new phases of education, both as it concerns the medical student and the practitioner. The trend in education poses many new problems and to those of us who give thought to this field they have caused some measure of concern. I, therefore, propose to call to your attention some aspects of the problem as I see them and some suggestions as to their correction.*

The changing world has necessitated a change in education. It has been said that education needs modernization. By "modern" one actually means "contemporary in time," because if one looks back and contemplates the teachings of the ancient philosophers, it will become apparent that they displayed not only a contemporary spirit but an outlook which was surprisingly modern in its thought.

Our modern education attempts to equip one to grapple with social problems as well as with the vast field of physical science. It is necessary to understand what forces create and modify our economic life and system. Under the rush of our present day educational system, the student gets only a superficial contact with the already overcrowded curriculum and by this superficial knowledge, he thus becomes a menace to the thinking of society. The student is only half-educated and is unaware of the limitations of his knowledge. By speaking to others as if he were omniscent, he improperly influences those with whom he comes into contact. Thus is formed false public opinion. The field of social sciences is so broad that the student never really gets a deep insight into any one of its various branches. This is true, no matter how long one continues to search into the realm of social science.

Applied science and technology are developments of modern education, and their study naturally leads the student to intensive and comprehensive study in one particular field—a form of specialization. No matter how expert one becomes in a particular science, it is important that he learn the purpose and ultimate application of his knowledge. The important task of education is to teach us to use our technicologic advances for the good of our fellow man. The Harvard report states that one of the aims of education is to break stranglehold of the present on the mind.

That system enjoys the greatest amount of liberty and freedom of thought in which the greatest number of beings can develop their peculiar abilities through a broad educational system which permits one to stand off at a distance and view the present day world in its true perspective based upon a knowledge gained from a study of the past.

Hume stated "that the sweetest path of Life leads through the avenues of learning and whoever can open up the way for another, ought, so far, to be esteemed a benefactor to mankind."

For a long time it has been apparent that there has been a decided lack of thoroughness in premedical education. The necessities of accelerating this phase of educational training and the abbreviation of the medical curriculum combined with a shortening of the period of internship brought on by the exigencies of war have left the young physician of today with a feeling of inadequacy. In addition, the number of premedical students was markedly depleted by lack of foresight shown by those in charge of the methods of induction of these young men into the Army and Navy. This has left a great void in the reservoir of potential physicians. It, therefore, is necessary that we slow down the continued tendency to rapid "short cuts" in education and restore the balance between the classical and scientific phases of education. It is important that the future physician, now more than ever, prepare himself for intellectual leadership by an education with a strong cultural and classical background.

The attempt to bring education to the masses has resulted in a lowering of the standard of education. It is quite obvious that, through proper training, research should be encouraged under our present economic system of free enterprise. Under this system have come the phenomenal advances in American medicine.

It has been said that there are many specialists but few experts. Since the war, more and more young doctors have been setting their sights at certification by the specialty examining boards. The preparation and study which these boards require have greatly increased the acumen and ability of these young physicians; and this has resulted in better medical care. As many applicants have learned, it has been found important to have a broad basic and classical education. Let it be hoped that the acquisition of this knowledge will be passed on to the public by continued intimate relationship between physician and patient.

It is to be hoped, too, that the young physician will not enter the practice of a specialty, until he

* The ideas here expressed are not entirely my own. They represent conclusions reached as a result of my experience, however, though many of the ideas have been culled from the literature on the general subject of education. J. I. E.

has had adequate experience in general practice as a family doctor. The present rules of most of the specialty examining boards encourage young men to enter residencies for specialized training immediately at the conclusion of a brief internship. This, in my opinion, is to be deplored. It would be better if the boards required that candidates have at least five years in general practice before they be permitted to take their examinations.

Further, the rules of the specialty boards make it almost impossible for a doctor to qualify for examination while continuing in the practice of medicine, to make a necessary living for his family. I have raised, and will continue to raise, my voice against this authoritarian and short-sighted system. Every opportunity should be afforded to any physician willing to make the necessary sacrifice in



DR. CLARENCE R. O'CROWLEY, GENERAL BROCK CHISHOLM AND DR. HARRISON S. MARTLAND

time and study to prepare himself for certification through such recognized courses as have been endorsed by this Academy and provided by the Essex County and other medical societies.

It is to be noted that practically all the medical schools in America have for a long time isolated themselves from the medical community at large and from the medical societies in particular. They have, it seems, concentrated on research problems. Little attention has been paid to the practical side of medical care which the physician per force must meet in daily practice in the home and in his responsibility to the community at large. It has been suggested by one of our members that each medical school adopt a course which would acquaint the medical student with the economic problems of medical practice and with the problems which confront organized medicine today. The future of medicine rests in these young men and yet we find that they are not conversant with the practical problems of organized medicine. They are well schooled in theory and research but they lack teaching in the field of economic and human relations.

The advent of federal and state agencies into consideration of individual and community medical problems makes it imperative that the medical student be prepared to meet these problems. There, therefore, has appeared a trend in some medical schools to recognize the necessity of introducing courses in the social and economic aspects of medical practice. It is to be hoped that these courses will be productive of much good.

There is a greatly increased demand for residencies and fellowships. There are far too few such opportunities available, but they are being provided as rapidly as the medical schools are able to acquire additional hospital facilities, providing additional teaching beds. This has resulted in more capable house physicians in many of the hospitals which have allied themselves with the medical schools, and thus in a higher standard of post-graduate education, in many a hospital, which



might otherwise not have had the benefit of such highly specialized contacts with institutions of learning.

Medical schools are cooperating with federal and state authorities and are, at the same time, receiving federal funds for much needed research projects. We must be careful to see that the giving of these funds does not carry with it undue federal control over the educational systems in our medical schools.

I hope that I have indicated to you some of the problems and trends in our modern medical educational system. I look forward to the future with great hope that the high standards of American medicine will be perpetuated under a system of free and unhampered enterprise.

CITATION TO DR. O'CROWLEY *

The physician whom we honor this evening was born in Newark and has lived here all his life. He received his education in the Newark schools, the Dwight School in New York, and was graduated as a physician from the College of Physicians and Surgeons, New York. After having been associated for twelve years

* By Dr. Harrison S. Martland.

with the late Ramon Guiteras, Professor of Urology at the New York Post-Graduate Medical School and Hospital, he became practically a pioneer in the practice of modern urology in New Jersey and has practiced exclusively in this field ever since. He was president of the Newark City Hospital for five terms, and for years has been a strong opponent of having any doctors receive their staff appointments through politics. He is Attending Surgeon and Chief of Department of Urology of the Newark City Hospital and Presbyterian Hospital, and Consulting Urologist to the following institutions:

Lutheran Memorial Hospital
Newark Beth Israel Hospital
St. Michael's Hospital
Eye and Ear Infirmary
Hospital for Crippled Children
Irvington General Hospital
Alexian Brothers Hospital, Elizabeth
Perth Amboy Hospital
West Hudson Hospital, Kearny
St. Mary's Hospital, Orange
Alexander Linn Hospital, Newton
Dover General Hospital, Dover
New Jersey State Hospital, Greystone Park
Essex County Isolation Hospital, Belleville
Newton Hospital, Newton

He was an instructor in Urology at the New York Post-Graduate Medical School and Hospital for ten years.

He is a Past-President of the—

American Urological Association
New York Urological Society
Essex County Medical Society
Essex County Pathological & Anatomical Society
Society of Surgeons of New Jersey

He is also a member of The Medical Society of New Jersey, the Essex County Medical Society, the Academy of Medicine of Northern New Jersey, American Medical Association, Society of Surgeons of New Jersey, New York Urological Society, American Urological Association, American Association of Genito-Urinary Surgeons, International Urological Society, and the American Association of University Professors. He is on the editorial board of the *American Journal of Surgery*, and he is a diplomate of The American Board of Urology, as well as a Charter Member of The American College of Surgeons.

This year he is president of The American Association of Genito-Urinary Surgeons. At present he holds the position of Assistant Professor of Urology in the Graduate School of the University of Pennsylvania.

Fifteen years ago he organized and developed the Urologic Service at the Newark City Hospital which was accepted for residency by the American Medical Association and The American College of Surgeons. His residents for the most part have been drawn from the University of Pennsylvania. After the doctor has received his first year basic course in urology and then receives the appointment as resident in urology at the Newark City Hospital, (during which time Dr. O'Crowley sees that the resident gets the proper practical training) the University of Pennsylvania accepts this as the second year toward the degree of M.S. in urology. Through this arrangement the Newark City Hospital is officially linked to the University of Pennsylvania, something that is not generally known.

Dr. O'Crowley has always worked for the interest of the younger men who wish to enter his field and helps them in every way possible with the advantages he has under his control. Many of the surgeons in our community and throughout the country owe their start in urology to our honored guest. Most of them have become very good urologists.

He has written many scientific articles. One of his most valiant efforts, though an unsuccessful one, was his untiring effort to have a grade A medical school in the State of New Jersey.

What urologists think of him is best summed up by Doctors Lowsley and Kirwin in their two-volume first edition of *Clinical Urology*. In presenting these text books to him, the following paragraphs were inscribed:

"This book is presented to my friend, Clarence R. O'Crowley, as a slight token of my friendship and because I think he has been an influence for good in American urology unequaled by any living man. With warmest personal regards and deepest affection, I remain Sincerely, Oswald S. Lowsley."

"To my friend and colleague, Clarence R. O'Crowley, teacher and surgeon, whose undivided efforts for the specialty of urology has made it one of the most accurate and respected of all. It it my sincere wish that he may find something of value in these volumes.—Tom Kirwin."

Now I am somewhat handicapped, since the honoring of this distinguished physician must be a dignified occasion, and as many of you know my "forte" is to make some Rebelasian wise-crack.

I am afraid both the committee and my dear friend have both been a little apprehensive of what I might say, but off the record, I must call your attention to a few more of his attainments:—He and his friends Professor

Willie MacTavish and Dr. Welton are the best story tellers and entertainers in the medical profession; his stories cannot always be repeated before the Woman's Auxiliary, and the late Hugh Young had nothing on him; he is noted for his lantern slide demonstration, *Larry turn the crank* and numerous other forms of amusement characteristic of urologists in general.

I am personally indebted to him for his many favors, for his prodding me to publish papers which would have never been written; for his saving of my life by his diagnostic ability and for his interest in pioneering the annual Martland lectures of the Pathological and Anatomical Society, in the procurement and entertainment of distinguished speakers, and in the lining up of the profession for the dinners preceding these social and scientific meetings.

I give you now Dr. Clarence Rutherford O'Crowley, loyal friend, skilled physician, teacher, writer, generous helper of fellow-workers and pupils, and leader in high-grade medicine in this community, whom the Academy is honoring tonight.

On behalf of the Academy I present to you. this plaque, upon which is inscribed:—

Scholarly Urologist
Resourceful Executive
Forceful Citizen

Larry, a host of friends and admirers offer their homage and sincere felicitations upon this occasion and with them go their best wishes for your health and happiness and for many years of beneficent and useful service to your fellow men.

DR. O'CROWLEY'S RESPONSE

"It is indeed a distinct honor to receive the Edward J. Ill Award of the Academy of Medicine of Northern New Jersey. That the selecting committee has seen fit, after careful and deliberate consideration, to choose me for the Award this year, makes me very proud and happy and I have not words at my command to express adequately by heartfelt thanks and appreciation.

After the flattering remarks of Dr. Martland relative to my sojourn in medicine these last forty years, and listening to past and present honors that I have been fortunate enough to receive, I can rightly say that this Award carries with it a very unique tribute, namely, that your colleagues in and around this part of the state decided that I should be the recipient of the outstanding Award at this meeting.

I have been helped greatly in this eminence by the faithful devotion, loyalty and cooperation of my numerous associates in the practice of urology in this part of the state. Likewise I wish to give credit for advancement in my chosen specialty to the many hospitals I am connected with for the advantages and help they have always given me.

My wife and son rejoice with me in having this great honor bestowed upon me. I thank you."

HONOR TO DR. DONOHOE

Only sixteen physicians now hold the distinguished title of Fellow of The Medical Society of New Jersey. Of these, the Senior Fellow, is Dr. Lucius F. Donohoe, of Bayonne, who became president of The Medical Society in 1924. In celebration of his twentieth anniversary as medical director of the Bayonne Hospital and Dispensary, his colleagues and friends assembled on June 5, 1947, to mark the occasion and to present a portrait of Dr. Donohoe by K. S. Williams. N.A. Dr. Morris J. Weiss was toastmaster and in a brief introduction outlined the distinguished career that had its modest beginnings in a humble workman's home, and that led to the office of chief executive of the city of his birth. Dr. Donohoe was characterized as "first citizen of Bayonne" by Judge John F. Drewen, one of the principal speakers of the occasion. The presentation speech was made by Dr. Madaras, who said:

We are gathered here tonight to honor a great doctor, a tireless public servant and an outstanding citizen; and I am indeed grateful for the privilege of representing the medical staff of the Bayonne Hospital on this happy occasion.

Dr. Lucius F. Donohoe, your life has been rich in accomplishments. In the service of your country you served with distinction as a colonel in the Medical Corps of the army in World War I and as chairman of the medical disaster corps of the Civilian Defense during World War II. For many years you held offices of public trust and as mayor of the City of Bayonne you responded to the highest calling of your fellow citizens. As president of The Medical Society of New Jersey, as president of the Hudson County Medical Society and as delegate to the American Medical Association, you brought to your profession a distinguished leader-

ship few men attain. Your achievements in surgery earned for you a fellowship in the American College of Surgeons.

You are the first Medical Director of the Bayonne Hospital and you have directed its administration continuously for more than fifty years. The Bayonne Hospital, under your leadership and watchful guidance, has grown to become one of New Jersey's finest institutions. You have been ever helpful to the intern, the student and the graduate nurse as well as to your fellow practitioner. By your charity and kindness you have been an example and inspiration to the profession.

Dr. Donohoe, I have the honor to present this portrait of you from the medical staff of the Bayonne Hospital as an expression of our affection for you and of our gratitude for your great works in the interest of our profession.

In response, Dr. Donohoe expressed his appreciation of the sentiments but minimized his own efforts and said the success of the hospital would not have been possible had he not had the loyal support of his competent staff. He said he was happy to have the opportunity to pay tribute to his associates and to the people of the city for the accomplishments and success of Bayonne Hospital.

"This gift, so generously given by my medical associates," he said, "will always be cherished by me and I know of no better place for its permanent location than in Bayonne Hospital with the portraits of my two predecessors."

Doctors at the dinner expressed admiration for the work of Keith Shaw Williams, N.A., the artist.

Co-chairmen in charge of the affair were Dr. Emil Grieco and Dr. Harold Sager.

BOARD OF TRUSTEES

APRIL 21, 1947

The regular annual meeting of the Board of Trustees was held April 21, 1947, in Atlantic City.

Present were: Dr. Crowe, Chairman, who presided, Dr. Lee, Dr. Schaaf, Dr. Scammell, Dr. Lance, Dr. Coleman, Dr. Alexander, Dr. Dodd, Dr. Norton, Dr. Hawkes, Dr. Young, Dr. Sica, Dr. Fithian, Dr. Green, Dr. Stahl, Dr. Johnsen, Dr. Costello and Dr. Hornberger. Also present upon invitation was Dr. Allman.

FINANCE AND BUDGET COMMITTEE

Dr. Allman, Chairman of the Finance and Budget Committee, presented the proposed budget for 1947-48, totalling $82,770, and recommended its approval. The Finance and Budget Committee also recommended that the assessment for 1948 be $20 per member.

On motion made, seconded and unanimously carried, the budget and assessment for 1948 of $20 per member was approved.

It was recommended that to compensate Mrs. Armstrong for her additional duties as Assistant Editor she be given an extra salary of $50 per month, and that this be made retroactive to April 1, 1947. Upon motion, seconded and unanimously carried, the recommendation of the Finance and Budget Committee was approved.

REFUND ON DUES

Dr. Schaaf stated that a recommendation would probably be presented to the House of Delegates that a refund be given of $5 per member on 1947 dues. He urged that the Board express an opinion on this matter so that representation can be made before the Reference Committee.

Following discussion Dr. Schaaf moved that no unexpended funds in any account be used to reimburse members for dues. Seconded by Dr. Coleman, this was unanimously carried.

Dr. Crowe requested Dr. Hawkes and Dr. Costello to appear before the Reference Committee to which this matter is referred and express the opinion of the Board of Trustees.

TERM OF A. M. A. DELEGATE

Dr. Schaaf moved that the terms of delegates to the American Medical Association be fixed to expire with the conclusion of the Annual Convention of the American Medical Association. Seconded by Dr. Stahl, this was unanimously carried. Accordingly, the term of a delegate elected for the 1946 and 1947 meetings of the A. M. A. will expire at the close of the 1947 Annual Convention of the Association.

RESOLUTION RE DR. STAHL

Dr. Schaaf offered the following resolution for approval by the Board:

That The Medical Society of New Jersey express to Dr. Alfred Stahl upon the occasion of the completion of ten years in office as Secretary, its ap-

preciation and gratitude for his loyal service. During this long tenure in office, which included the difficult war years, he served the Society faithfully and with distinction. Be it further resolved that this expression of gratitude be recorded and published in the TRANSACTIONS.

Upon motion by Dr. Schaaf, seconded by Dr. Alexander and unanimously carried, the above resolution was approved.

Dr. Schaaf moved that the Society present to Dr. Stahl, in recognition of his years of service as Secretary, a Society Key, engraved—"Secretary—1937-1947". Seconded by Dr. Coleman, this was unanimously carried.

PHYSICIANS ON HOSPITAL STAFFS

At the request of Dr. Hawkes, Dr. Schaaf presented the following resolution:

THAT THE MEDICAL SOCIETY OF NEW JERSEY ADVOCATE:

(1) That great care be exercised in selecting physicians for appointment to the medical boards of hospitals; that their educational preparation, their scientific qualifications, their standing in the community, their moral standards, their adherence to the codes of their profession be carefully considered and that they be nominated for appointment by the existing medical board of each individual hospital.

(2) That any physician, having been thus carefully selected, nominated by the medical board, and appointed by the trustees of any hospital, shall become secure in that appointment, not subject to annual reappointment, but may be removed by the board of trustees of that hospital whenever in the opinion of the trustees such removal will be to the welfare of the hospital.

Dr. Hawkes felt that if The Medical Society of New Jersey recorded itself as approving such an idea it would carry some weight with the American Medical Association and the American College of Surgeons, who have designated that all staff appointments shall be on annual basis.

Dr. Hawkes moved that the Trustees approve offering the above resolution to the House of Delegates for action. The motion was seconded and lost. On motion made by Dr. Schaaf and unanimously carried, it was agreed that the resolution be referred to a special committee of the Trustees for study.

FALL CLINICAL CONFERENCE

Dr. Schaaf asked the Trustees to endorse a proposal to resume the Fall Clinical Conference, provision for which is already included in the budget. Upon motion, seconded and unanimously carried the Trustees approved holding the Fall Clinical Conference.

Dr. Johnsen moved that an *Elias J. Marsh Oration* be held on the last night of the Fall Clinical Conference. Seconded by Dr. Norton, this was unanimously carried.

MALPRACTICE INSURANCE

As a result of a recent malpractice suit against a member of the Essex County Medical Society and the subsequent discussions relative to obtaining reinstatement of full coverage for this member, Dr. Schaaf presented the following resolution:

WHEREAS, one insurance company has a monopoly on malpractice insurance in New Jersey, and

WHEREAS, this situation may permit arbitrary action on the part of this insurance company to the possible detriment of our members, therefore

BE IT RESOLVED, that the Committee on Medical Defense and Insurance of The Medical Society of New Jersey be directed to explore the possibilities of securing additional insurance companies who will be willing to write malpractice insurance in New Jersey.

Upon motion by Dr. Schaaf, seconded by Dr. Lance and unanimously carried, the above resolution was adopted.

DUES CREDIT FOR VETERANS

Dr. Green read the following communication from the Essex County Medical Society, addressed to Mrs. Madden under date of April 11, 1947.

"Members who returned from service between January 1, 1946, and October 1, 1946, are the only veterans so far who have not received a dues credit for the year following their return. This action appears to be discriminatory.

"We are, therefore, suggesting that the House of Delegates reconsider its action and allow a dues credit for 1947 to members who returned from service during the time specified."

Dr. Schaaf moved that all physician-veterans who were members of The Medical Society of New Jersey, in good standing, at the time of entrance into military service be entitled to one full year's credit or remission of dues after discharge. Seconded by Dr. Stahl, this was unanimously carried.

EMERITUS MEMBERS

Dr. Green read the following communication from the Essex County Medical Society, addressed to Mrs. Madden under date of April 11, 1947.

"The Essex County Medical Society requests that the House of Delegates or the Board of Trustees

consider the matter of the remission of dues to all members who are permanently incapacitated by age or infirmities and are unable to continue the practice of medicine."

Dr. Schaaf explained that the Essex County Medical Society would like approval of this in principle so that a resolution can be presented to the House of Delegates suggesting the creation of a new group of members to be known as "Emeritus Members".

Dr. Schaaf moved that an appropriate constitutional change be introduced to the House of Delegates to carry out the suggestion of the Essex County Medical Society. Seconded by Dr. Sica, this was unanimously carried.

GRADUATE STUDENTS

Dr. Green read the following communication from the Essex County Medical Society, addressed to Mrs. Madden under date of April 11, 1947.

"The Essex County Medical Society requests that The Medical Society of New Jersey remit the dues of those members who are taking full-time graduate training under the 'G I Bill of Rights' and who are not in the private practice of medicine."

Dr. Costello moved that this request be disapproved. The motion to disapprove was seconded and carried.

COMMITTEE ON MEDICAL CARE

The following resolution from the Monmouth County Medical Society was read by Dr. Green:

WHEREAS the recent national election has provided a year or two of "breathing space" for the medical profession to make good medical services more available to all people in New Jersey at all income levels, particularly in low income families, and

WHEREAS it is essential that more effective means be provided at once to accomplish this goal, with the aid of our allied professions and all public and private agencies concerned with this outstanding problem, therefore

BE IT RESOLVED that, to accomplish this purpose, the President of The Medical Society of New Jersey appoint a special Committee for Medical Care (of seven of the most able members of the Society), to include five Past-Presidents, to lay out a complete detailed plan for good medical care for every person in New Jersey,—the plan to be ready within ninety days; this Committee to have all facilities and staff of the Society placed at its disposal to expedite the study, and

BE IT FURTHER RESOLVED that the House of Delegates of The Medical Society of New Jersey include the sum of $20,000 in the budget for the coming year, and direct that it be efficiently used to employ a professional public relations expert to establish as promptly as possible at both state and county levels, a sound complete program, which will make available good medical services to all people in New Jersey, particularly in low income families, and

BE IT FURTHER RESOLVED, that the Public Relations Committee, working with the Public Relations Committees of the county medical societies, create a state and county working relationship with the health professions, the governmental and private agencies, and the organizations representing the larger consumer groups, to meet this outstanding need in a manner that will convince the public of the sincerity and ability of the medical profession to see that good medical services are made available to every person at any income level in this state, whenever such person shall make it known that good medical services are not available to him.

Suggested Budget Items

Trained public relations expert	$10,000
State and administrative office expenses	5,000
State public relations assistance to twenty-one county medical societies public relations Programs	5,000
	$20,000

Following discussion Dr. Schaaf moved that the resolution of the Monmouth County Medical Society be approved in principle, insofar as it relates to the appointment of a special committee of seven members to develop a detailed plan for good medical care in New Jersey. The motion was seconded and lost.

WORKMEN'S COMPENSATION FEES

Dr. Green read communications from Dr. William K. Harryman relative to increased fees for workmen's compensation cases. Dr. Harryman expressed the opinion that the best approach for increasing fees is through the individual physician and the insurance company. He also suggeted that action by county medical societies might be helpful.

Dr. Costello moved that the opinions of Dr. Harryman be concurred in, and that the contents of his communications be published in the JOURNAL. This motion was unanimously carried.

INDOCTRINATION OF MEDICAL STUDENTS AND INTERNS

Dr. Green read the following resolution from the Essex County Medical Society:

"The Essex County Medical Society submits the following resolution for consideration and approval by The Medical Society of New Jersey, with the request that, should they concur it be presented by its delegates to the A. M. A. at its next annual meeting.

"Whereas the new social philosophy being evolved in this country has confronted organized medicine with many vital and perplexing problems and

"Whereas the burden of meeting these problems, and at the same time retaining those attributes which experience has taught are vital in maintaining the standards of medical care, is now being borne almost entirely by the more mature members of our profession, and

"Whereas it is recognized that the doctor of tomorrow who is the student of today, will be the future standard-bearer of our profession, and

"Whereas there is a formative period of six to eight years wherein the student and intern receives his scientific training and lays the foundation for his professional philosophy, and

"Whereas to prepare the physician properly to carry on the work now being performed by organized medicine, his curriculum should be supplemented by a program that would indoctrinate him with the philosophy and ethics of our organization. This program should emphasize the relationship to, and the responsibility of the doctor in meeting the social problems now confronting our profession.

"Therefore be it resolved that the American Medical Association inaugurate a program which will systematically contact every medical student in each approved medical school, also those recently graduated, now serving internship or other graduate training. The program should supplement his scientific training with such facts and information as will fulfill the desires incorporated in this resolution. Preference should be given to a brief recognized course of instruction within the curriculum of each approved medical school, or by any other practical means deemed proper by the A. M. A.

Dr. Schaaf moved that this resolution take the usual course through the House of Delegates, without recommendation from the Trustees. The motion was unanimously carried.

MEDICAL SERVICE ADMINISTRATION

Dr. Green read a communication from Dr. Scott requesting the nomination for members for the Board of Governors of Medical Service Administration and the Board of Trustees of Medical-Surgical Plan for 1947-48. The present members are:

Medical Service Administration:
Harry N. Comando, M.D.
Samuel A. Cosgrove, M.D.
Augustus S. Knight, M.D.
Thomas K. Lewis, M.D.
Mr. George W. Merck
Royal A. Schaaf, M.D.
Edward W. Sprague, M.D.
Mr. John S. Thompson

Medical-Surgical Plan
Harry N. Comando, M.D.
Samuel A. Cosgrove, M.D.
William E. Dodd, M.D.
Augustus S. Knight, M.D.
Thomas K. Lewis, M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Norman M. Scott, M.D.
Edward W. Sprague, M.D.
Mr. John S. Thompson

Dr. Costello moved that the present members of the Board of Governors of Medical Service Administration and the Board of Trustees of Medical-Surgical Plan be placed in nomination for membership on the respective Boards for 1947-48. Seconded by Dr. Scammell, this was unanimously carried.

INSURANCE FEES

Dr. Green read the following resolution from the Union County Medical Society:

The Union County Medical Society endorses the following action of the Tennessee State Medical Association and asks the Medical Society of the State of New Jersey to do the same.

Resolved that it is the sense of the Tennessee State Medical Association in meeting assembled that we deplore the injustice of the insurance companies of America toward the medical profession in their failure to raise the five dollar fee paid for medical examinations for more than seventy-five years. This rank unfairness is accentuated by the fact that the entire financial structure of life insurance is erected and its solvency based on the integrity and professional ability of the examining physician. Moreover, this flagrant violation of fair practice on the part of all life insurance companies is made more glaring by the fact that no account is taken of the increased cost of medical education, medical equipment and medical expenses, including transition from the horse and buggy to the automobile age.

Be it further resolved that we ask the fee for a life insurance examination to be ten dollars with all other medical insurance fees to be raised in proportion.

Dr. Schaaf moved that this resolution take the usual course through the House of Delegates without recommendation from the Trustees. Seconded by Dr. Scammell, this was unanimously carried.

BOARD OF NURSES EXAMINERS

Dr. Green read a communication from the New Jersey State Board of Examiners of Nurses requesting a representative from this Medical Society as a member of a group of consultants whose counsel can be requested in relation to the legal responsibilities of the Board as a State Commission.

Dr. Costello moved that the Chairman of the Advisory Committee on Nursing and Nurs-

ing Education be designated as a representative of The Medical Society of New Jersey on the group to be set up by the Board of Nurses Examiners. This motion was unanimously carried.

HOSPITAL PRACTICE OF MEDICINE

Dr. Green read the opinion * from counsel on the question of whether the Hospital Service Plan of New Jersey in contracting to provide x-ray and pathologic examinations, in connection with its policy of hospital insurance, is performing an illegal act.

Dr. Johnsen moved that the Chairman of the Board appoint a special committee to meet with the Chairman of the Committee on Radiology and the Chairman of the Committee on Clinical Pathology relative to this opinion and bring in a recommendation to the Board of Trustees. Seconded by Dr. Young, this was unanimously carried.

Upon motion, seconded and unanimously carried, the meeting was adjourned at 11:00 p. m.

DAVID W. GREEN, M.D.,
Secretary.

April 24, 1947

The reorganization meeting of the Board of Trustees was held April 24, 1947, in Atlantic City.

Present were: Dr. Crowe, Dr. Schaaf, Dr. Young, Dr. Lee, Dr. Costello, Dr. Lance, Dr. Allman, Dr. Sica, Dr. Coleman, Dr. Hawkes, Dr. Johnsen, Dr. Dodd, Dr. Green, Dr. Wood, Dr. Scammell and Dr. Norton. Dr. Hornberger was excused. Also present as guests, were Dr. Scott, Dr. Barkhorn, Dr. Londrigan, Dr. Evans and Dr. Ulmer. Dr. Lee presided until the election of a Chairman. Dr. Schaaf nominated Dr. Aldrich C. Crowe for Chairman of the Board of Trustees for 1947-48. Upon motion the nominations were closed and the Secretary cast a ballot declaring Dr. Crowe elected Chairman of the Board. Dr. Costello nominated Dr. David W. Green for Secretary of the Board of Trustees for 1947-48. Upon motion the nominations were closed and the Chairman cast a ballot declaring Dr. Green elected Secretary of the Board.

Dr. Lee, whose membership on the Finance and Budget Committee from the Trustees expired this year, requested that he not be considered for re-election.

Dr. Schaaf nominated Dr. David B. Allman for Trustee member on the Finance and Budget Committee. Upon motion, the nominations were closed and the Secretary cast a ballot declaring Dr. Allman elected to the Finance and Budget Committee.

PRINCIPLES OF COOPERATION

Dr. Scott presented the *Principles of Cooperation* between organized medicine and health and welfare agencies of New Jersey, which the Society has agreed to have printed at the request of the Council on Medical Service of the American Medical Association. These principles will be included in a brochure to be entitled *Implementing the National Health Program of the American Medical Association in New Jersey.* The brochure will contain the Ten-Point Program of the A.M.A., the *Principles of Cooperation,* a brief resume of the program of the Society, the Monmouth County Plan of cooperation with health and welfare agencies, and the City of Newark Medical Care Plan.

Upon motion by Dr. Schaaf, seconded by Dr. Green and unanimously carried it was directed that a proof of the brochure be submitted to each member of the Board for study, that the Trustees indicate their approval or disapproval, and that Dr. Scott be notified of the results.

HEALTH COUNCIL

Dr. Schaaf reported that Governor Driscoll said he would write formally to The Medical Society of New Jersey asking us to submit the names of physicians for candidates on the Health Council of the State Department of Health. The Governor also stated he would informally ask the advice of the Medical Society in the selection of certain laymen on the Council.

Dr. Schaaf read a note from Dr. Stanley Nichols suggesting the consideration of certain specific members in making these recommendations to the Governor. He also suggested that the Governor be urged to appoint Dr. Robert C. Clothier, President of Rutgers University, to the Council.

Dr. Schaaf asked the members of the Board to give this matter serious thought and be prepared to offer suggestions when the formal request is received from the Governor.

SEARCH FOR EXECUTIVE OFFICER

It was regularly moved, seconded and unanimously carried, that a committee of the Trustees be reappointed to continue the search for a suitable Executive Officer for The Medical Society of New Jersey.

* A full copy of this opinion is available at the Executive office.

Chairman Crowe appointed the following committee:

Dr. Royal A. Schaaf, Chairman
Dr. William F. Costello
Dr. James F. Norton

COMMITTEE ON AUXILIARY SERVICES

It was regularly moved, seconded and unanimously carried that the Chairman appoint a special committee to carry out the action of the Trustees on April 21st relative to the opinion received from counsel (April 18th) and to consider the matter of fees for cases treated under the Crippled Children Commission, the State Board of Children's Guardians, and the Division of Old Age Assistance. The Chairman designated this committee of the Board as the Special Committee on Auxiliary Services and appointed Dr. Elton W. Lance, Chairman, Dr. Sigurd W. Johnsen and Dr. L. Samuel Sica.

NATIONAL PHYSICIANS COMMITTEE

Dr. Londrigan, Chairman of the New Jersey Physicians Committee, requested that the Society reaffirm its approval of the activities of the National Physicians Committee. Reason for this request is that opponents of the Committee are pointing out that approval of the activities of the Committee has not been reaffirmed since 1945.

Dr. Costello moved that the Trustees reaffirm the position taken in 1945 in approving the work that is being done by the National Physicians Committee. Seconded by Dr. Johnsen, this was unanimously carried.

It was directed that a copy of this action be forwarded to Mr. Arthur Conrad of Chicago.

NEW BUSINESS

Dr. Schaaf read a telegram from Dr. Hornberger asking to be excused from the meeting of the Board because of the serious illness of Mrs. Hornberger.

Upon motion, seconded and unanimously carried, it was directed that the Trustees express their sympathy and best wishes to Mrs. Hornberger.

Dr. Chester I. Ulmer and Dr. J. Lawrence Evans, members of Reference Committee "A", appeared before the Board to oppose the employment of a layman as Executive Officer. Following discussion of the matter the Board voted to go into executive session.

Dr. Schaaf moved that the 1948 Annual Meeting of The Medical Society of New Jersey be held April 26th to 29th at Haddon Hall, Atlantic City. Seconded by Dr. Norton this was unanimously carried.

Because of the great demand for May dates for conventions in Atlantic City Dr. Schaaf moved that Dr. Allman investigate the available dates for the 1949 Annual Meeting of The Medical Society of New Jersey, with due regard to proximity of the A. M. A. meeting and select a date in May, if possible. This was unanimously carried.

The meeting was adjourned upon motion at 4:45 p. m.

David W. Green, M.D.,
Secretary.

PUBLIC RELATIONS AND ACCOMPLISHMENTS of THE MEDICAL SOCIETY OF NEW JERSEY

Sometimes one hears a member of the Society, in a derogatory tone of voice ask, "What has The Medical Society of New Jersey accomplished?" He refers to the public relations program of the Society and its objectives. He is usually a member not active in the affairs of the Society or he is an individual so absorbed in his private affairs that he has not given time to consider or evaluate the accomplishments of the Society.

There will always be critics. There will be those who, usually because of limited knowledge, believe they could do a better job. And unfortunately, there will probably always be some few individuals who bring discredit upon the accomplishments of the profession. However, all things considered, there can be no doubt that the accomplishments of the Society have raised the esteem of the profession in the eyes of the public.

A satisfactory definition of medical public relations has yet to be written. But, certain qualifications and means of evaluating a given public relations program are apparent.

The program and its objectives must represent the social conscience of the group, not of

the individual physician. It must primarily promote the health and welfare of the people, not primarily promote the welfare of the medical profession or individual physician. Both the program and its objectives must be carried out with loyalty, with honesty and with a dignity befitting the medical profession. The best public relations agent of the medical profession is the satisfied patient, whether he be millionaire or indigent.

The results of the program are evolutionary and cumulative. They may be measured by the activities and accomplishments of the Society and its members in promoting the health and welfare of the public. Some of the activities inaugurated in recent years by the Society, or by other agencies with which the Society and its members cooperate, and which conform to the qualifications outlined above, are as follows:

Two hundred and seventy-four Baby Keep Well Stations, each clinic session at each Station being attended by a member of the Society who by experience and training is particularly fitted for this work.

Sixty Mental Hygiene clinics, each clinic session being attended by one or more recognized neuropsychiatrists.

Many tuberculosis clinics, each clinic session attended by a physician accomplished in the diagnosis and treatment of tuberculosis.

New Jersey Municipal Aid Administration program through which state financial aid is available to all communities for medical care of the indigent, and which at present operates in an area representing over 90 per cent of our population, with members of the Society cooperating in each community.

The programs of the following state agencies providing medical care on a categorical basis: New Jersey Commission for the Blind, New Jersey Crippled Children's Commission, New Jersey State Board of Children's Guardians, New Jersey Old Age Assistance Commission, New Jersey Rehabilitation Commission and New Jersey Workmen's Compensation Commission.

The Cancer Program. The Cancer Committee of the Society, cooperating with the New Jersey Division of the American Cancer Society, has established twenty diagnostic-therapeutic cancer clinics, and ten diagnostic cancer clinics, each clinic session attended by members of our hospital staffs under the chairmanship of a physician specializing in cancer. Physicians may refer any indigent or medically indigent person to these clinics where he will be assured of adequate attention without cost. The New Jersey Society of Clinical Pathologists cooperates by rendering free service for the diagnostic examination of biopsy specimens submitted to its members by physicians from indigent or medically indigent patients.

Medical-Surgical Plan of New Jersey. A voluntary, non-profit, pre-payment medical care plan, organized by the Society for the purpose of assisting persons overtaken with illnesses requiring hospitalization by providing benefits for services rendered by physicians to patients admitted to hospitals for treatment, and as a means of providing complete payment for such services rendered persons of low income. Over 3400 members of the Society are Participating Physicians. As of May 31, 1947, the enrollment in the Plan was 109,251 persons with an additional 5,728 persons enrolled under contracts with future effective dates, for a total of 114,979 persons.

Medical Service Administration of New Jersey. A non-profit medical service corporation organized by the Society for the purpose of studying the medical care problems of the indigent and low income group, and evolving plans to solve this problem. It has demonstrated to the satisfaction of its governing board that an adequate program for this economic group cannot be evolved on an insurance basis and has evolved an alternate basis in the form of a reimbursement plan as operated by the Administration for the benefit of the indigent and medically indigent of the City of Newark. Its latest contribution is the "Principles of Cooperation between Organized Medicine and Health and Welfare Agencies" as adopted by the House of Delegates of the American Medical Association at its recent annual meeting (see page 281 of this JOURNAL).

The Legislative Committee of the Society gives careful study to every legislative bill introduced into the State Legislature and National Congress, affecting the health and welfare of the public. Upon the recommendations of this Committee the Society gives vigorous support to all legislation promoting the health and welfare of the people and just as vigorously opposes legislation which is adverse to the welfare of the people.

And so the public relations and general program of the Society evolves, through the activities of its various committees, always with the purpose of improving public welfare rather than the welfare of the profession, the only approach through which the profession can maintain and enhance the esteem of the public.

NORMAN M. SCOTT, M.D.

WELFARE COMMITTEE

Organization meeting of the Welfare Committee was held on Sunday, May 25, 1947, State Society Headquarters, Trenton, Dr. Vincent P. Butler, Chairman, presiding.

ATTENDANCE:

Dr. Vincent P. Butler, Chairman
Dr. Royal A. Schaaf, President
Dr. Earl L. Wood, Secretary

Dr. Edward Guion, Atlantic County
Dr. D. Ward Scanlan

Dr. John L. Olpp, Bergen County
Dr. Harold C. Essertier

Dr. R. Winfield Betts, Burlington County
Dr. William E. Bray

Dr. Arthur G. Pratt, Camden County
Dr. H. Wesley Jack

Dr. Albert B. Kump, Cumberland County

Dr. Marcus H. Greifinger, Essex County
Dr. Harrold A. Murray
Dr. Harry N. Comando

Dr. J. Lawrence Evans, Hudson County

Dr. Barclay S. Fuhrmann, Hunterdon County

Dr. L. Samuel Sica, Mercer County
Dr. Walter E. D'Arcy

Dr. Ralph J. Faulkingham, Middlesex County
Dr. John H. Rowland

Dr. C. Byron Blaisdell, Monmouth County
Dr. Stanley Nichols
Dr. Louis F. Albright

Dr. Salvatore Giordano, Morris County
Dr. George L. Nicoll

Dr. Raymond A. Taylor, Ocean County
Dr. Carmine L. Pecora

Dr. H. Hale Hollingsworth, Passaic County
Dr. Morris Joseph

Dr. Harry F. Suter, Salem County

Dr. Herschel S. Murphy, Union County
Dr. Thomas J. Walsh
Dr. Watson B. Morris

Dr. Ralph M. L. Buchanan, Warren County

CONSULTANTS:

Mr. John J. Debus
Mr. William H. MacDonald

GUESTS:

Miss Grace Anderson
Dr. James O. Hill
Dr. Norman M. Scott
Dr. Jerome G. Kaufman
Dr. E. P. Ruffy
Dr. William E. Dodd
Dr. Abraham E. Jaffin
Dr. Asher Yaguda
Dr. W. James Marquis
Dr. Daniel Bergsma
Dr. C. Chester Chianese
Dr. G. E. McDonnel
Dr. B. S. Troedsson
Mrs. A. G. Pratt
Mrs. Edward H. Dyer
Dr. C. B. Whims
Mrs. D. E. Kavanaugh
Mrs. Louis L. Perkel
Mrs. Asher Yaguda
Mrs. L. Mancusi-Ungaro

DR. BUTLER: Before doing anything else I would like to express appreciation of the confidence that the president has placed in me in asking me to serve as chairman of this important committee. I realize that I can do practically nothing without the support of the subcommittees and the members of this committee. I am sure, as in the past, that support will be forthcoming. This has been a very useful committee to the Society and I am sure it will continue to be.

DR. SCHAAF: It has been customary for the president of the Society to outline his program for the coming year at the first meeting of the Welfare Committee. It is a mistake, however, for the president to say he has a program. Actually the president should be a coordinator of all the activities of the Society and lend his weight where needed. If you start the year with the thought that you will devote all attention to one thing you slight the others. Committees deal with many phases of our work, and they will have controversial problems of one type or another. It should be the president's job to pilot them along the proper channels.

In selecting Dr. Butler as chairman we have an experienced man who will bring enthusiasm to the work and will coordinate the activities of the Subcommittees. He has a guiding function which is very important, and to facilitate that work, I suggest that he consider periodic conferences with the chairmen of the subcommittees.

At the present moment there are certain major issues. The first, of course, is legislation, state and national. At the moment our own legislature is not in session, and no more bills such as A-30 and A-88 will be introduced until the next session. During the past season, we had 100 per cent batting average in defeating undesirable legislation, and we may thank our legislative committee, especially Dr. Pollak, Dr. Quigley and Dr. Hill. I would call especial attention to Dr. Hill's signal service

for this Society, and regret that he has found it impossible to continue in the legislature.

In national legislation we have the new Wagner-Murray-Dingell Bill and the Taft-Fulbright Bill, which we don't want; and we have the Taft-Smith-Ball-Donnell Bill, which we do want with minor modification. A delegation from your Society will go to Washington in June to appear before the Senate Subcommittee on Health.

We have the matter of hospital relations which is looming large, and the problem of contract practice of medicine by hospitals. These institutions are prëempting more and more privileges and prerogatives of medical practice, and we should try to bring better understanding between organized medicine and the hospital group. Medical care of the indigent is in a fair way of adequately being cared for. Medical Service Administration is functionng well and is doing a magnificent job with the indigent and medically indigent.

Another problem of major importance is that of nursing and nursing education. The present unusual shortage of nurses may get worse, and we must devote our attentions to ways for increasing enrollment of nurses in our hospital training schools. All other committees under the Medical Practice Committee are important, of course, but I am just picking out some of the major problems.

The committee on cancer control has a big year ahead of it. Our own committee has done a magnificent piece of work in setting up, a biopsy service and enunciating our philosophy and plans for coriduct of these various clinics, and our cooperation with the American Cancer Society, at the moment, is 100 per cent. The cardio-vascular disease committee is going to have a big program, about which Dr. Kaufman will tell us later. I have merely spotted a few of the high points to show that the year will be very active.

Here the problems of the various committees are critically studied, and by and large every recommendation coming out of this committee receives thorough study by the Trustees. The Trustees realize that careful consideration has been given to each suggestion. You should realize that every time you make a recommendation or resolution it carries weight with the Trustees. Actually most of the Society's work rests with the deliberations of the Welfare Committee.

WOMAN'S AUXILIARY

DR. DODD: It is in this Committee and its subcommittees and advisory committees that the actual work of the Society gets its going over, and it is here that the problems are discussed and the work is actually done. In other words these committees are the hands of the Society. Now, we have other hands that are willing and anxious to help in the problems confronting the Medical Society. I speak of the Woman's Auxiliary. In the Woman's Auxiliary you have a potential force that can help us with every problem that confronts the Society. I am anxious that the activities of the Woman's Auxiliary be brought into closer relation, and that the Woman's Auxiliary be called upon to give more help to the Society in the problems that confront them. During the coming year, under the leadership of Mrs. Mancusi-Ungaro, I am sure you are going to see the Auxiliary becoming more and more active in our problems. Already they have a comprehensive program by which the doctors' wives of this state will take a more prominent part in molding public opinion. This is vital to the welfare of organized medicine. A round table meeting has been arranged for June 16, at which time the chairmen of the subcommittees and advisory committees will meet with the corresponding chairmen of the Woman's Auxiliary committees. To this will be invited the chairmen in each county Auxiliary to discuss these common problems, and to find some practical way in which the Woman's Auxiliary can help. They are willing but they want to be told in what way they can best help. To express this more fully I would like to present Mrs. Mancusi-Ungaro, President of the Woman's Auxiliary.

MRS. MANCUSI-UNGARO: I am deeply appreciative of the honor of appearing before you, and would pause to thank my predecessors whose fine work has brought about this, and Dr. Schaaf for its accomplishment in his administration. On behalf of the Auxiliary I should like also to express my appreciation to you for our adviser, Dr. Dodd, and his fine committee.

All over the country women's groups are taking an interest in legislation; it is prevalent in all of the clubs with which we are affiliated. Health education too is a popular phase of modern club work, and if our organization is to justify its existence as other than a social group, if it is to be of any value to you in public relations work among women's clubs, not only must we be informed but we must also take the leadership under your direction, and mold, insofar as we are able, the thinking of these groups.

To do this we must start right here. Your Society has 4869 members, but the Auxiliary

has only 952. I must underscore the importance of a large Auxiliary membership in each county. There are eight unorganized counties: Bergen, Cape May, Cumberland, Hunterdon, Morris, Salem, Somerset and Sussex. In these eight counties, unless the individual physicians take the time to help their wives understand the problems of organized medicine, policy forming movements among women's groups do not in any way feel the guidance of the Medical Society. It is imperative that the county medical societies follow the example set here today, and help train the leaders of tomorrow by including them on committees where they can be of help.

With the permission of my Advisers, and the consent of my Executive Board, I respectfully present the following program of work for the Auxiliary for the year 1947-1948:

1. Promote friendliness among the wives of physicians.
2. Increase Auxiliary membership.
3. Organize unorganized counties.
4. Assist the Medical Society at all times when requested.
5. Promote *Hygeia*.
6. Actively support all health movements endorsed by the Medical Society.
7. Promulgate favorable publicity for physicians through all media of communication.
8. Coordinate and integrate the functioning of the component Auxiliary committees with the corresponding committees of the Medical Society by means of a workshop once a year.
9. See that our members know the stand of all legislators on health questions, and that analyses of pending legislation be distributed effectively.
10. Assume leadership among the women's groups of New Jersey in health education.

With the permission of Dr. Schaaf, Dr. Blaugrund and Dr. Dodd we have gone ahead and have set up for June 16 an informal round table discussion on four problems:

1. Health of Women in Industry—Commissioner Harper, Chairman.
2. Alcoholism—A member of Alcoholics Anonymous, Chairman.
3. Traffic Accidents of Children—Colonel Schoefel of the State Police, Chairman.
4. Student Nurse Enrollment—Dean, N. J. College for Women, Chairman.

In the afternoon we will have a speaker from the American Medical Association, Dr. Dean F. Smiley, Chairman of their Health Education Committee. You are all welcome and we would like to have you come.

SUBCOMMITTEE ON LEGISLATION

Dr. Herschel Murphy read a report on the subcommittee on legislation, submitted by Dr. Pollak. (This is printed on page 288, this issue.)

Upon motion, seconded and unanimously carried, the report of the subcommittee on legislation was accepted.

DR. SCHAAF: County Societies should ascertain the name of the family physician of each legislator, and then have the Keyman go, with the family physician, and have a personal interview with the senator or assemblyman. From experience in this field I know that this is an invaluable approach. You can get more this way than by seeing him in the State House. If your Keyman approaches your legislator with the legislator's family physician he gets off to a good start. If our Keymen would follow out that suggestion we would have a great deal more weight with our legislators.

At a hearing in June, a delegation from this Society, consisting of Dr. Scott, Dr. Quigley, Dr. Alexander, Dr. Butler, Dr. Hornberger, Dr. Norton, Dr. Crowe and myself, will appear before the Senate Subcommittee on Health in Washington. This paper that I shall read has been written by Dr. Quigley after consultation with members of the delegation, and we present it for your approval.

I move that the Welfare Committee approve for presentation at the hearing the statement just read. (Seconded and unanimously carried.)

SUBCOMMITTEE ON MEDICAL PRACTICE

Dr. Murphy, Chairman of the Medical Practice Committee, read the report of his Committee. (See page 290 this JOURNAL.)

Dr. Murphy moved that the portion of the report dealing with workmen's compensation be approved. Seconded and unanimously carried.

Dr. Murphy moved that the portion of the report dealing with the practice of medicine by hospitals in the fields of anesthesiology, radiology, physiotherapy and clinical pathology be approved. Seconded and unanimously carried.

Dr. Murphy moved that the portion of the report dealing with the definition of a public health center be approved. Seconded and unanimously carried.

SUBCOMMITTEE ON PUBLIC HEALTH

DR. MURRAY: The major goal of the subcommittee on public health will be the consummation of programs started in the past years, especially in tuberculosis, cancer and venereal disease. One prime focus will be on the prevention and treatment of heart disease. Also we plan to hold a public health week in New Jersey in October. In the beginning, the thought was to have a centralized plan of public health information. Now we feel it is rather late and the individual counties, with the aid of the Auxiliary, will be asked to cooperate to formulate their own programs of public health. In Essex County we plan an intensive week of public health instruction, radio broadcasts, editorials, exhibits, and on the 9th we have invited Dr. Parran, Surgeon General of the U. S. Public Health Service, to speak to us. That program can be, and should be copied in other counties. The Woman's Auxiliary is anxious to help in any way possible. There are no recommendations to be presented, but I will ask Dr. Kaufman to outline the plan of his heart campaign.

DR. KAUFMAN: During last year my committee made a survey of cardiac facilities in New Jersey. This revealed that cardiac facilities are inadequate in our state. We have planned a program, not only to establish facilities but to set in motion an educational project in each county, and to outline a program so that individual counties may establish their own heart centers, similar to those approved by the Heart Association. It will require more than a year to develop. Heart disease is the number one cause of death. It certainly needs better facilities in this state than we have. Most of the counties have no facilities at all. I hope that next year our report will be much more favorable.

Dr. Murray moved that the report of the Public Health Committee be accepted. Seconded and unanimously carried.

EXECUTIVE OFFICER

DR. SCHAAF: The question of the selection of an Executive Officer has come up a number of times. Last year, the new veterans care program was just being put into effect. We had a new contract which became effective in June 1946. That called for the selection of an Executive Officer to be assigned to Veterans Administration as a liaison officer. Under the contract we finally negotiated, the Veterans Alministration paid for this liaison officer. We selected Dr. Edward T. Yorke and assigned him to the VA. He has done excellent work. That left the $10,000 appropriated for the Executive Officer untouched. The Committee then reviewed all the applicants which we had from our first canvass, seeking some one from our own Society. No one seemed to want the job. We have qualified men in the Society but they would not take it. We communicated with a large placement agency in Chicago and received several applications. They were mostly elderly retired Army and Navy Medical Officers. They were all in their sixties. We finally found a good young man, but he withdrew just as we were about to appoint him. That left us without a candidate. On several occasions, we discussed with the Trustees the possible selection of a layman as Executive Officer. His duties would be those of a public relations official. Public relations has almost become a new science. Throughout the country, at present all state and county societies which have Executive Officers, with four exceptions, do have laymen. There is even an organization of laymen who are Executive Officers of state and county societies, and it is a good group. One man was seriously considered, but a month ago he declined the offer.

The basis of any public relations program is telling the public what you have done and what you are doing and what you expect to do. In this state we enjoy an exceptionally good public relations program with the Governor, county officials and with the general public, and there is only one reason—we are able to demonstrate to them that our sole interest as an organization is in the general welfare of the public. The legislators will continue to support us if we continue to demonstrate our interest is all in the welfare of the general public. We have done things and we are doing things and we will do things in the public interest, and we should be in a position to discuss them with lay groups, and a good Executive Officer offers an excellent medium for that kind of discussion.

ANNOUNCEMENTS

Dr. Butler announced that the meetings of the Welfare Committee will be as follows: September 14, 1947, December 14, 1947, and March 7, 1948. The 1948 Annual Meeting will be held during the week beginning April 25, at Haddon Hall.

MEDICAL SERVICE ADMINISTRATION

DR. SCOTT: With legislation similar to the Taft Bill in the offing it behooves us to study and develop means of applying the provisions of that bill locally. We have had considerable experience in this state in dealing with the low income group on two bases: one on the

basis of insurance and the other on the basis of reimbursement. I think we have demonstrated that care of the individual is not best on the insurance principle. We must develop some other means of meeting the problem. We have demonstrated that it can be done on reimbursement basis by our experience with the Newark Plan.

We appeared before the Senate last December and presented our views on the Taft bill, particularly on the principle of the reimbursement plan. As a result, reimbursements are recognized in the present Taft Bill. It has brought the problem to the forefront—that is our experience in Newark. The American Medical Association has asked us to prepare a pamphlet outlining our experience here, and how we believe the Taft bill could be made effective. I will distribute copies of this pamphlet. The important part of this brochure ("Implementing the National Health Program of the American Medical Association in New Jersey") is the statement of principles of cooperation between organized medicine and voluntary and official health agencies. This is the first time that any state society has enunciated such principles, which should be applicable to any county or any state in the union. These will be distributed through the Council on Medical Service of the A. M. A. and will be available at their booth in Atlantic City. How successful we would be in applying these on a state-wide basis through Medical Service Administration remains to be seen. We don't want to repeat our experience in the VA where we were limited by so many regulations. But given a free hand, Medical Service Administration could evolve a state-wide program, placing an act like the Taft bill on a state-wide basis. Read this pamphlet. I also wish you would read the brochure published by Marjorie Shearon, *Blueprint for the Nationalization of Medicine.* It will be of particular interest in connection with testimony to be given by proponents of compulsory sickness insurance.

Medical-Surgical Plan is our main effort at present. We are unable to expand our program for the indigent and medically indigent until proper appropriations are made. The enrollment of Medical-Surgical Plan is 105,000 persons. It will be about 110,000 by the end of May 1947. That is not rapid expansion, but that slow expansion has kept us financially sound. We are expanding according to our plans so as to maintain our financial safety. We want to thank all of our participating physicians. We have very few complaints from either physicians or patients. We try to pay promptly—within two weeks. We try to pay the fairest fees consistent with the financial safety of the Plan.

The meeting was adjourned upon motion at 3.45 p. m.

REPORT OF SUBCOMMITTEE ON LEGISLATION

MAY 25, 1947

The supplementary report of this subcommittee, (made to the House of Delegates on April 22) embraced all the major legislation with which we were concerned. Brief additional comment should be made with respect to the matter of cash sickness benefits The Administration measure (the Brescher Bill), was not brought to a vote in the Assembly because caucus of the majority party disclosed that it lacked four or five votes. It undoubtedly could have been passed with the help of the minority party, but being an administrative measure responsibility for its passage was to be credited to the majority party. The bill is a modification of the California Plan and provides for the operation of *voluntary* plans and also for *state operated* plans for those unwilling to provide voluntary plans of cash sickness benefits.

Your committee registered its opposition to this bill. This action is consistent with the attitude assumed by the committee at the very beginning of consideration of cash sickness benefits over a year ago; namely, that such a plan should be, in our judgment, a state *supervised* system, and not a state *operated* plan. Governor Driscoll seems intent upon securing passage of this measure.

The serious threat of two bills to lower educational standards of those seeking a license to practice medicine, and the bill to establish a separate board of chiropractic examiners, which were before the Legislature this past session, disclosed clearly the need of improvement in county societies as to methods and technics for handling such emergencies on the county level. This Committee is addressing itself to this problem and hopes, with the advice and suggestions of county Keymen and officers, to outline a program in advance of

the next legislative session, which may be productive of improvement in this very vital work of the Society.

FEDERAL LEGISLATION

The Committee naturally is very much concerned with S. 545, the Taft-Smith-Ball-Donnell Bill, and with the statement to be submitted by representatives of our Society to the Senate Subcommittee on Health, at a hearing on this measure to be held in Washington next month.

We here summarize the major purposes of the bill and discuss the attitude of the Society with respect to the philosophy of the measure. Title I of the bill proposes to place all health activities of the federal government, (except those of the Army, Navy and Veterans Administration) in a single agency: the Federal Health Agency. The second major purpose is to appropriate two hundred million dollars a year for five years to the states to aid in the establishment of plans and programs by the states to improve medical, dental and hospital services to "individuals and families with low income". Approval of Title I of this bill, in view of the impossibility at this time of the establishment of a federal department of health, seems eminently sensible and a logical step toward this objective. Our greatest concern is with Title VII, grants-in-aid to states for improved medical care services.

Last fall a memorandum was sent to all state medical societies by the Council on Medical Services of the American Medical Association, requesting suggestions and criticisms of the former version of S. 545, preliminary to a discussion which the Council on Medical Service was shortly to hold with Senator Taft. The memorandum from our Society, in reply, expressed appreciation of the Council's procedure in attempting to ascertain the views of constituent state societies, and expressed the hope that the method would be continued. In our memorandum, which was approved by the Board of Trustees, we expressed approval of federal grants-in-aid to states for improvement of medical care services for individuals and families in the low income group, but strongly advocated that the grants-in-aid be limited to those states which demonstrated financial inability to meet this need without assistance from the federal government. And we predicated our position here upon the "Platform of the A. M.A.", adopted by its House of Delegates in 1944. Paragraph D of the "Platform" states, "The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick *on proof* of such need". (Italics ours.)

This is the position that the Society will take if the statement to be submitted at the hearing on this bill, which President Schaaf will read at the completion of this report, meets with the approval of the Welfare Committee at its meeting today. (Statement on file in Executive Offices.)

Hearings on the bill started last week. Senator Taft, medical Congressmen and the American Medical Association representatives, Dr. Sensenich, (Chairman of the Board of Trustees) and Dr. McCormick, (Chairman of the Council on Medical Service) testified. The hearings will end on June 13th, the "big gun" on that date being Watson B. Miller, Federal Security Administrator. Following this, the Senate Subcommittee on Health will hear witnesses on the new version of the Wagner-Murray-Dingell Bill. Introduction of this bill by Senator Murray was originally scheduled for May 12, but was postponed to May 20, so as to follow promptly President Truman's pronunciamento of the 19th on compulsory sickness insurance. It is our understanding that in view of the prolonged hearings held last year on the Wagner-Murray-Dingell Bill it was felt by the Senate Subcommittee on Health that there was no need for extended discussion on the compulsory viewpoint this year.

Respectfully submitted,

B. S. Pollak, M.D.,
Chairman.

OBITUARY

DR. ALBERT T. MURPHY

Dr. Albert T. Murphy, a practicing physician in Elizabeth and a member of the medical staffs of St. Elizabeth and Alexian Brothers hospitals for more than 25 years, died on May 16, 1947, in the latter institution, at the age of 56.

A native of Johnstown, Pa., he was graduated from Jefferson Medical College in 1915, and interned at Gouveneur Hospital, New York, where he served for a time as house physician. He was a captain in the U. S. Army Medical Corps during World War I.

Always interested in industrial medicine, Dr. Murphy recently had been engaged in research in that field. He was a member of Union County Medical Society and was active in local fraternal organizations.

SUBCOMMITTEE ON MEDICAL PRACTICE

At the May 25 (1947) meeting, Dr. Harryman, Chairman of the advisory committee on workmen's compensation, reported that his committee had communicated with the Newark Casualty Insurance Company, the New Jersey Self-Assurance Association, and the New Jersey Claim Association. All were cooperative and favorable toward the increase in fees for compensation work. The revised summary of the Workmen's Compensation Law of the State of New Jersey will soon be mailed out to all members of the Society.

Upon motion the subcommittee recommends that the Welfare Committee request the Trustees to authorize the printing (with a cover) of this revised summary of the New Jersey Compensation Laws and that a copy be mailed to each member of the Society.

Dr. D'Arcy, Chairman of the advisory committee on nursing and nursing education, gave a progress report and stated his committee would be glad to consider anything referred to them.

Dr. Ulmer, reported by letter, that the new fifth edition of the New Jersey Formulary is now on the press and will be ready soon for distribution to the members.

Report from Dr. Blackburne, stated that the principles of the Newark Plan and the "Principles of Cooperation" of The Medical Society of New Jersey are taking on real importance in view of the provisions of the Taft Bill for grants-in-aid to states for medical care of the needy.

Dr. Yaguda, Chairman of the committee on laboratory medicine, stated that his committee hoped to have definite recommendations for the fall meeting.

Dr. Walker reported for the committee on anesthesiology to the same effect.

Dr. Marquis, Chairman of the committee on radiology, presented a request of the Board of Trustees that "the Welfare Committee investigate and report to the Board the nature of violations of the principles of the practice of medicine by hospitals in the fields of anesthesiology, radiology, physiotherapy and clinical pathology."

Upon motion, the subcommittee recommends that this request be recognized and the Welfare Committee be requested to refer this matter to the subcommittee on medical practice for study.

Dr. Troedsson reported that his committee on physical medicine hoped to have definite recommendations for the fall meeting as to the place of physical medicine in the hospital organization.

Dr. Snavely reported that his committee on hospital relationships would consider the study of the intern problem and such other matters as were referred to his committee.

The "Definition of a Public Health Center" as conceived by the State Department of Health was referred to the subcommittee for opinion by President Schaaf. This definition will be studied during the summer and final action will be taken at the fall meeting.

SUBCOMMITTEE ON PUBLIC RELATIONS

When I was asked by Dr. Alexander in 1945 to be chairman of the public relations committee, I made it clear to him that I knew nothing about this work. Dr. Alexander said he wanted a physician in Trenton to head the committee and for the present we would initiate projects that would, when the war was over, be established programs at which time we would secure the services of a qualified Executive Officer to carry them on. Since then I have learned more about the work and have seen the need of such an officer.

We have tried to secure a qualified man, but to date have not succeeded. Some months ago we appropriated $10,000 for this office, but for some reason it did not attract anyone.

Dr. Scott and Dr. Davidson could give the job only part of their time. A good public relations program requires a constant stream of press releases, radio time, contacts, procurement and placement of speakers, preparation of posters, staging of exhibits, etc.

Public relations is no longer an activity which a well-meaning volunteer member can do in his off time; hundreds of other enterprises are constantly competing with ours for the public ear and eye, and the public will listen where its attention is most vigorously directed. We want our *Health Hints* continued. —To write them requires time. They should be written by a specialist and referred to the Trenton office for editing. I will add this: when Dr. Scott was doing them, he could never get a physician to contribute one. Radio broadcasts should be continued. The A. M. A. makes platters available for the broadcasts and many stations will donate the time.

There are many contacts that should be re-

established and maintained—welfare agencies, unions, service clubs, allied societies, etc.

We have approved the suggestion of a health week, but who can give it the time and the organization it requires?

We have approved the activities of the Health Congress and they are looking forward to a public relations committee from this Society to help put it over. Money has been allotted to this committee that would be spent on public relations.

We give a fraction of one dollar of our state dues to public relations; Michigan gives more than $20.00 per member, and Virginia, a smaller state than ours, gives four times as much as we do.

I strongly recommend the early selection of an Executive Officer, whose major duties will be public relations.

It has been suggested that we ask New York or Pennsylvania Medical Societies to include our state in their coverage and pay a pro-rata share of the work. I am not in favor of this. Another suggestion was to abandon all pretense to any full scale public relations program. I do not believe the members of the society would want this.

I would recommend that we ask the Trustees to increase the appropriation for this office now.

We wish to report that one of the more recent good works done in public relations is the pamphlet "Implementing the National Health Program of the A. M.A. in New Jersey", as prepared by this Society for the Council on Medical Service of the A. M. A. We request your approval of the printing and distribution of this pamphlet to each member of the Society.

L. SAMUEL SICA, M.D., Chairman.

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Chairman Nutrition Committee

1. *Does milk tend to make older people more susceptible to arthritis?*

   The calcium content of milk may be deposited around the joints in the aged. Oxalic acid foods act as a binder of calcium. If these are eliminated from the diet milk may be given to the aged without any concern for arthritis. Avoid the following foods which are high in oxalic acid:

Asparagus	Cocoa	Pepper
Beans	Coffee	Plums
Beets	Cranberries	Potatoes
Black tea	Endive	Rhubarb
Bread crust	Figs, dried	Sorrel
Chicory	Gooseberries	Spinach
Chocolate	Green beans	

2. *Many patients with neuritis do not seem to get the desired therapeutic value from thiamine hydrochloride. Why?*

   First, thiamine should be given in conjunction with other members of the B complex and vitamin C. Second, an increased amount of carbohydrates should be added to the diet.

3. *Why are fats hard to digest?*

   On the contrary fats are just as easily digested as proteins or carbohydrates. Fats have a higher satiety value, and fulness usually results after a meal rich in fats because these retard the emptying of the stomach. Digestion and satiety value are two different things.

4. *Is it necessary to give vitamins to patients with gastric ulcers?*

   Vitamin C is of benefit and should be given in doses of 500 mg. to 1000 mg. per day.

5. *Should patients with heart disease take vitamin B complex or any other vitamins?*

   Vitamin E is useful in the following types of heart disease: hypertensive, rheumatic, arteriosclerotic, and coronary disease. It is non-toxic and like insulin must be taken continuously over a long period of time.

6. *Has vitamin D any value in tuberculosis of the skin?*

   In lupus vulgaris and similar skin conditions prescribe calciferol 2000 units per kilo per day plus two quarts of milk. These cases should be watched for toxic reactions from vitamin D: headaches, loss of appetite, nausea, vomiting, frequent micturation and dizziness.

7. *What type of blood sugar is indicative of diabetes?*

Take a fasting blood sugar. Send the patient out for breakfast and take another blood sugar an hour and a half later. If the second blood sugar is twenty to thirty per cent over the fasting one the patient has diabetes.

8. *Is it harmful for obese patients who are on diets to lose weight rapidly?*

Rapid loss of weight will produce any one or more of the following conditions: ptosis of the kidney, peripheral edema, vaso constriction of peripheral vessels, peripheral neuritis, hepatic enlargement, kidney stones or gall stones.

THE MEDICAL SOCIETY OF NEW JERSEY
SUPPLEMENTARY LIST NO. 2 TO THE 1947 OFFICIAL LIST

Abers, Bernard D., 565 Summit av., Jersey City (9)
Alessi, Alfred A., 174 Merrison st., Teaneck (2)
Audi, Eugene J., 466 South Maple av., Glen Rock (2)
Bassett, Samuel F., 355 Washington av., Dumont (2)
Bergen, Marshall, 2685 Boulevard, Jersey City (9)
Brakeley, Elizabeth, 71 Myrtle av., Montclair (7)
Braun, Edgar M., 105 Shanley av., Newark (7)
Brescia, James S., 29 Franklin tpke., Waldwick (2)
Brizard, Joseph L., 135 S. Center st., Orange (7)
Campo, Guy, 401 Broadway, Westville (8)
Carmen, Fletcher F., 21 Parkway, Montclair (7)
Connell, John N., 26 Carlton av., Jersey City (9)
Dallio, Salvatore J., 463 Passaic av., Lodi (2)
Dewis, Edwin G., 21 Westra st., Interlaken (13)
Dolan, Gerald J., 118 Broadway, Hillsdale (2)
Driggs, Marshall F., 242 Engle st., Englewood (2)
Duisberg, Richard, State Hospital, Marlboro (13)
Fechner, Fred, 846 Garrison av., Teaneck (2)
Fechner, Herta, 846 Garrison av., Teaneck (2)
Fenimore, Edward D., 77 Grace st., Jersey City (9)
Ferrante, Joseph, 309 Third pl., Palisade Park (2)
Fessler, William, 31 Knox av., Cliffside Park (2)
Fineberg, Jacob C., 50 Glenwood av., Jersey City (9)
Folsome, Clair Edwin, 1075 Central av.,Plainfield(20)
Gencher, Benjamin, 30 Small av., Caldwell (7)
Gillespie, J. Lawrence, 26 Midland av., Arlington (7)
Grant, Russell B., 100 Prospect av., Hackensack (2)
Grossman, Morris, 921 Bergen av., Jersey City (9)
Hall, Perry O., 2553 Boulevard, Jersey City (9)
Halpern, Morton, Wildwood (5)
Harrington, Walter L., 104 S. Munn av., E.Orange(7)
Haskin, Aaron H., 22 Goldsmith av., Newark (7)
Hauck, Francis A., 47th & Landis sts., Sea Isle City(5)
Hawkin, Edward Robert, 472 Union av.,Elizab'th(20)
Hitschmann, Otto B., 97 Lincoln Park, Newark (7)
Hopper, John B., East Main st., Mendham (14)
Horowitz, Robert, 2616 Boulevard, Jersey City (9)
Husik, Franklin, 101 S. Main st., Glasboro (8)
Kearney, John V., 335 - 78th st., No. Bergen (9)
Kesselman, Samuel B., 29 Stratford pl., Newark (7)
Kissinger, D. J., 411 Cedar lane, Teaneck (2)
Lerman, Sam, 116 Brightside av., Pikesville,Md.(20)
Levitov, Leo, 179 Wilkinson av., Jersey City (9)
Lipshutz, Ben, 18 West 22nd st., Bayonne (9)
Litwer, Herman, 100 Bentley av., Jersey City (9)
Livingston, Sidney R., 650 W. 7th st., Plainfield (20)
London, Isabel M., 103 N. 4th av., Highland Pk.(12)
Lueddecke, Roland E., 216 Randolph av., East Rutherford (2)
Martin, Eugene, Belvidere (21)
Martin, Leonard J., 206 Prospect av., Asbury Pk.(13)
Mick, Edwin C., 46 S. Burnett st., East Orange (7)
Milligan, R. S., 42 Elm st., Summit (20)
Moolten, Sylvan E., 103 N. 4th av., Highland Pk.(12)
Newman, A. J., 132 Manhattan av., Jersey City (9)
O'Sullivan, J. R., 11 Quincy av., Arlington (9)
Parker, James W., 175 Shrewsbury av., Red Bk.(13)
Perrone, Arthur F., 415 - 60th st., W. New York (9)
Pindar, A. W., 627 Queen Anne rd., Teaneck (2)
Piskorski, A. V., 604 Jersey av., Jersey City (9)
Read, Erwin R., 125 Marsellus pl., Garfield (2)
Riordan, John P., 40 Midland av., Arlington (9)
Rubin, Bernard D., 849 Avenue C, Bayonne (9)
Rush, Martin R., 326 Broad st., Red Bank (13)
Russillo, Philip, 155 Clerk st., Jersey City (9)
Ruttenberg, Louis, 19 Hopkins av., Woodbury (8)
Santoro, Thomas A., 141 Sanford st., E. Orange (7)
Schulman, Abraham S., 4518 Hudson Boulevard Union City (9)
Scott, Kenneth Hazen, 734 Park av., Plainfield (20)
Sigman, George, 254 Union st., Jersey City (9)
Snyder, Wm. Jay, 74 Columbia ter., Weehawken (9)
Sooy, L. Thomas, 202 W. Holly av., Pitman (8)
Sottilaro, Joseph, 1921 Boulevard, Jersey City (9)
Spicola, L. A., 294 Union st., Lodi (2)
Starr, Eli, 16 - 62nd st., West New York (9)
Street, Daniel B., 27 Woodlawn av., Jersey City (9)
Szittya, Sandor, Main st., Phillipsburg (21)
Teschner, Bernard M., 4808 Bergenline av., Union City (9)
Tyon, Edward, Ocean City (5)
Vaughan, J. Maurice, 825 Kaighn av., Camden (4)
Weinstock, Michael B., 1 Johnson av., Newark (7)
Weston, Elaine, 40 Midland av., Arlington (9)
Wollack, Alfred R., 9 Park av., Park Ridge (2)
Wood, Oran A., 128 W. Broad st., Paulsboro (8)
Wren, James C., 79 Everett st., Closter (2)

ASSOCIATE MEMBERS

Bass, Morris, 414 Chancellor av., Newark (7)
Cockburn, Wilfred P., 48 E. Kinney st., Newark (7)
Einhorn, Harvey P., 241 Sixteenth av., Newark (7)
Francis, Adaline M., 210 Manville Homes, Manville (12)
Gear, Phillip E. D., 340 Belmont av., Newark (7)
Geringer, Benjamin, 37 Fulton st., Newark (7)
Merliss, Harry, 386 Clinton av., Newark (7)
Rich, Robert E., 191 Littleton av., Newark (7)
Strassburger, Paul J., 330 Washington av., Belleville (7)
Zimmer, Louis E., 192 Alexander st., Newark (7)

VETERANS CARE PLAN

THE HOME-FRONT PHYSICIAN

The physician who remained on the home front during the recent war has become a comfort to all veterans, who, in this state, enjoy a remarkably wide choice of physicians. This is possible only because of the willingness of the physician who has a large community of patients to stand by as a participating member of The Medical Society in the program of the Veterans Administration.

The task of making specific reports on the findings and results of treatment, the uncertainty of a veteran's eligibility as a beneficiary of the VA, and certain peculiarities inherent in VA's methods cause the half-hearted physician to shy away from treating veterans, except at the latters' expense.

Physicians of The Medical Society *en masse* have been declared eligible to treat veterans for the VA because the only sound policy is that of giving the widest possible choice of physician. Also, a physician who is generally reluctant to treat VA beneficiaries may have a veteran come to him and, in this special case, be willing to engage in the throes of VA paper-work. A physician is eligible to treat VA beneficiaries so long as he is a member of The Medical Society.

CONFLICTS WITH VA

No physician serves his medical society well when he takes it upon himself to engage in conflict with the people who work in the Veterans Administration. As a representative of the physician, I am occasionally put in an awkward position. A stinging piece of correspondence by an irritated physician to VA does not have the effect the doctor intends. When a physician tosses dignity out the window he has lost something. All other presumptive gains cannot make up for this loss. And, most important, it brings a poor reflection upon The Medical Society.

Your representative* with the VA can serve your purpose remarkably well, because he will understand that a certain something is being blown off the chest and will keep the undesirable expressions to himself. By hearing from as many physicians as possible, your representative becomes informed in just the manner desired by the Medical Society and the Veterans Administration.

CUTTING TREATMENT VISITS

We took the initiative in reducing the treatment of veterans to normal practice. There will be times when a medical employee of VA will reduce a physician's request for treatment below the margin of safety. This will come about because of a zeal to get well within VA's directives on treatment visits.

Reducing the number of authorized treatments does not reflect upon the honesty of the physician. Politicians have been looking over Dr. Hawley's VA program. They have been looking at us. We should not become apprehensive; yet we should stick to the wheel of treating veterans with a mind to keep the cost down. It is a burden getting the veteran to understand this; yet, as intelligent people, we are capable of meeting the situation. It is shameful for a physician to open his heart and the government's purse strings by bestowing a superfluous type of medical care to VA beneficiaries.

OUR PROGRAM IS WORKING

The treatment of veterans at government expense is not strictly a VA program. With total participation of the members of The Medical Society on the basis of free and wide choice of physician by veterans the program is as much ours. The responsibilities of the VA are real enough; yet without the special ingredient, practice of medicine, and its widest possible application, there would be no program. Fortunately, a majority of the members of The Medical Society have had a vivid appreciation of this fact.

INDEX OF PHYSICIANS

Our index of physicians requires continuous revision. It is a source of information on available medical service for VA patients. When a physician writes to me, giving his qualifications, he signifies his support of the program. There is no steering of veterans to certain physicians.

PAYMENT OF BILLS

Remarkable strides have been made in the elimination of lost motion in the section of Regional Office of VA which initiates payment of physicians' bills. All bills submitted up to March have been processed. The backlog is being reduced materially, according to Mr. Thomas Grimley, assistant to Mr. Harold Hoenig, Chief Administrative Officer.

Edward T. Yorke, M.D.,
Medical Liaison Officer.

* Telephone extension 457 at MArket 3-6800 or write to Dr. Edward Yorke, Room 316, Veterans Administration, 20 Washington Place, Newark 2.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

Working Partnership Exhibit at A. M. A.

Public health in New Jersey was represented at the Centennial Meeting of the American Medical Association, Atlantic City, in June by a New Jersey State Department of Health exhibit demonstrating the working partnership which has long existed between New Jersey's physicians and Health Department.

Widespread interest was created by the exhibit which was designed and built in the Health Education Workshop of the State Department. Mr. John B. Van Ellis, Assistant Chief, Division of Health Education, designed and supervised construction of the exhibit.

The exhibit, which was shown in the Scientific Exhibit Section, was viewed by thousands who attended the Convention and nearly 300 physicians stopped to register at the booth, requesting that special information be sent to them regarding New Jersey's public health program. Representatives registered from 27 of the 48 states, as well as from India, England, Argentina, Cuba, Philippines, Panama, Lebanon, Finland, Guatemala, Portugal, China and Syria. Foreign representatives were particularly interested in New Jersey's public health program.

SIX PHASES SHOWN

Six phases of the public health program in which physicians and health departments work together for better health are portrayed in the exhibit. The mass chest x-ray program of the Tuberculosis Control Division which has provided over 250,000 free chest x-rays for New Jersey residents is described. All suspected cases of tuberculosis found in this program are referred to the family physician.

The penicillin treatment program of the Division of Venereal Disease Control in which the family physician plays the central role is shown. Communicable disease control, spearheaded by the family physician who sees the patient first is portrayed showing State Health Department services which include diagnostic service of the Bureau of Bacteriology, free biologicals distributed by the Bureau of Local Health Services and the health education program of the State Department of Health.

The "Anticipatory Guidance" of the Division of Maternal and Child Health which is aimed at preventing development of personality maladjustments and neuroses by proper parent-child relationships through education of parents by physicians and child hygiene nurses is depicted.

The recently established tumor registry of the Division of Cancer Control which will provide a service for surgeons and pathologists is described in the exhibit.

Cooperation between the industrial physician and the health department through the Division of Adult and Industrial Health for the protection of industrial workers of the state is shown.

Heart Education Program

Nearly 100 New Jersey theaters have now booked the new film on disease of the heart and circulatory system "Be Your Age" produced by the American Heart Association and the Metropolitan Life Insurance Company.

The film is being used in New Jersey as part of the education program of the New Jersey State Department of Health. State and county tuberculosis leagues are assisting in the promotion of the film, as is the New Jersey Health Officers' Association and local health departments.

"Be Your Age" is the dramatic story of middle- aged, overweight John's recovery from a heart attack and his consequent adjustment to and acceptance of living with a handicapped heart. Among other things he learns, through x-ray motion picture shots, how the normal heart acts when it rests and when it works, and why doctors advise plenty of sleep and rest for the protection of the middle-aged healthy heart and the care of the sick heart. John, along with about four million Americans with imperfect hearts, can expect to live without premature heart failure and enjoy life, if he will eat, work and play in moderation.

Booking cards have been sent to all theater managers in New Jersey and additional cards may be secured from the Health Education Division, State Department of Health, Trenton 7, New Jersey. The film will be available in 16mm size for use by local groups from the Metropolitan Life Insurance Company, 1 Madison Avenue, New York, New York, after January 1, 1948.

COUNTY SOCIETY REPORTS

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society*, held at Bergen Pines Hospital, Oradell, on the evening of April 8, was called to order by the President, DR. ALBERT W. CLOUD, at 9:20 p. m.

The minutes of the regular meeting of March 11 were accepted as read by the secretary. The minutes of the Executive Committee meeting of March 18 were approved as published in the *Bulletin*.

On recommendation of the Membership Committee, the following applicants were elected to full membership: Drs. Joseph Ferranti, Palisades Park; Milton Abarbanel, Rochelle Park, (by transfer from Hudson County Medical Society); Milton B. Sloane, Englewood, (by transfer from Medical Society of the County of New York); James S. Brescia, Waldwick; Salvatore V. Dallio, Lodi; Gerald J. Dolan, Hillside; Alfred R. Wollack, Park Ridge; Russell B. Grant, Hackensack; and James C. Wren, Closter. Drs. Vincent J. Catanzaro, Garfield; Victor Drucker, Teaneck; and Ralph J. Fioretti, Rochelle Park, were elected to Associate membership.

Dr. W. K. Harryman, Chairman of the Industrial Medicine Committee, moved that the Bergen County Medical Society go on record as approving the minimum charge on compensation cases as follows: $3.00 for office visits, $4.00 for house or hospital visits, $5.00 for first aid, with proportionate increase where special work is required.

The speaker of the evening, DR. GEORGE S. GOODHART, Scientific Director, National Vitamin Foundation, New York City, was introduced by DR. GEORGE HELLER. His topic was *Recent Advances in Nutrition and the Care of Deficiency Disease*. Interesting items gleaned from his talk were: Recent studies in protein have shown the requirements to be more closely related to surface area than to body weight. Optimum protein intake can only be stated when caloric requirements are met. Protein and Vitamin B are now considered to be the best therapy in liver disease. Intravenous protein feedings should be given only as a last resort because, on the one hand, there have been reactions to the protein itself, and on the other hand, the fluid load necessary to carry adequate protein may be too much for a debilitated subject. The effectiveness of vitamin intake may be affected by the diet, and lastly nutritional edema can result with normal plasma protein levels and is thought to be primarily a manifestation of caloric deprivation. Dr. Goodhart closed his talk by expressing many more of the newer concepts of vitamin and mineral metabolism.

Dr. Heller presented DR. CHARLES BLEASBY, a member of the Bergen County Board of Chosen Freeholders, who explained the details of the Bergen County Hospital Plan from his viewpoint, which opposes that of Dr. Samuel Alexander, as recorded in the minutes of the March meeting. Again there was keen interest manifested in the subsequent discussion and question period.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The monthly meeting of the *Burlington County Medical Society* was held at the Riverton Country Club on April 10.

The President, Dr. Bray, read the revised Constitution and By-Laws, which were voted on and accepted by the members.

It is with sadness that the County Society reports the death of DR. JOSEPH STOKES, SR., of Moorestown, on April 7, 1947.

The guest speaker of the evening was DR. EDWARD WEISS, Professor of Medicine, Temple University, who spoke on psycho-somatic aspects of cardiovascular disease. He stated that psychosomatic medicine is the introduction of psychiatry into medicine. Dr. Weiss divided his talk into three parts: the effect of the emotions on; (1) the normal heart; (2) the diseased heart; and (3) hypertension. He stated that the real approach is to discover what is causing the patient's anxiety and discuss it with him. This rather new approach to some heart conditions was explained very clearly by Dr. Weiss. It was a most interesting talk and extremely well presented. It gave all the members a new light on some of their problems.

Following Dr. Weiss's talk the John Wyeth Company presented colored sound pictures on drip therapy of peptic ulcer. It was an interesting and instructive picture.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The April meeting of the *Camden County Medical Society* was held on April 1, at the Camden City Dispensary, with DR. HENRY DECKER, president presiding.

Members elected at the last meeting were introduced to the Society. Dr. H. R. Limer was proposed for membership. Dr. Garrison was elected to membership.

The speaker of the evening was DR. JOHN H. GIBBON, JR., Professor of Surgery and Director of Surgical Research at the Jefferson Medical College. His subject was *Diagnosis and Operability of Pulmonary Cancer*.

Cancer of the lung is very common, much more so than recognized. In making a diagnosis, history and bronchoscopy are the most important things. Ninety per cent of the patients are males. Lantern slides were shown of pathologic specimens and microscopic sections.

The paper was discussed by Dr. T. J. Summey, guest from Burlington County Medical Society, Dr. Martin Collier and Dr. Robert Gamon. Dr. Gibbon's paper was greatly enjoyed by all and he was given a vote of thanks by the Society.

The memorial to DR. CLARA HORNER ROGER was read by Dr. Helen F. Schrack. The memorial to DR. MILTON OSMUN was read by Dr. David Bentley.

Dr. Martin Collier, chairman of the Public Health Committee, reported on the Mobile Clinic for Sight

Conservation. It was recommended and approved by the Society.

Dr. Collier spoke on the advisability of having all patients and out patients in the hospital x-rayed. Two to four per cent of patients show tuberculosis. It is hoped to get the approval of the State and County Societies to have this done. This was approved by the Society.

Due to increased membership, the Society is entitled to additional delegates to the annual meeting of The Medical Society of New Jersey. The delegates appointed are Dr. George German and Dr. Robert Gamon. Alternates are Dr. Penrose Thompson and Dr. Robert N. Bowen.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The regular monthly meeting of the *Monmouth County Medical Society* was held on Wednesday evening, May 28, at the Monmouth Memorial Hospital. The speaker of the evening was Dr. Jule Eisenbud, Associate Professor in Psychiatry at the College of Physicians and Surgeons, Columbia University. Dr. Eisenbud is also an instructor at the New York School of Social Work. Dr. Eisenbud's subject was one of great interest to all medical men, namely: *Psychosomatic Fundamentals.* Psychosomatic medicine has been practiced since ancient times. Examples of such practice were found in the writings of the Persians. All disease entities have a psychic aspect as well as a somatic side. Dr. Eisenbud cited numerous examples of remarkable cures of psychosomatic medicine as well as many equally remarkable cures of the Cultist and Christian Scientists. These groups, therefore, do serve some beneficial effect. There are different picture patterns that the symptoms assume. These will follow closely the actual symptoms of heart disease or peptic ulcer or arthritis. One can almost predict the pattern which a patient will follow by understanding the mental conflicts that are present in a given individual. These conditions are best treated by the general practitioner and it is only in the severe cases that it is necessary for a psychiatrist to be consulted.

The ensuing discussion was opened by Dr. Frank Altschul.

The business meeting followed the scientific session. The following doctors were elected to full membership: Dr. Aaron Heisen, Imlaystown; Dr. Frederick Hummel, Manasquan; Dr. Victor Thompson, Keyport; Dr. Leonard Schneider, Bradley Beach, and Dr. Chester Raphael, Marlboro. Dr. John Movelle of Fair Haven, and Dr. Peter Spagnolo of Asbury Park were elected to associate membership.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday evening, May 20, as part of the Centennial Celebration at the State Teachers College in Paterson. Dr. Harry Wolfson, our President, presided.

The following officers were unanimously elected: President, Leon E. De Yoe; Vice-President, J. Allen Yager; 2nd Vice-President, Irving Okin; Secretary, John E. Leach; Treasurer, Theodore K. Graham; Reporter, Leopold E. Thron; Editor, Joseph E. Mott; Board of Censors, William M. Sullivan, Howard H. Nye, Harry Wolfson.

The following applicant physicians were elected to membership: Active membership—Salvatore T. Ferrari, Isadore M. Schnee and Leonard V. Strully, of Paterson; John R. Mabee, Little Falls; Irving A. Schultz, Fairlawn, and Anthony F. Palmeri, of Clifton; associate membership—Frank H. Burchill, Stanley T. Jurewicz and Joseph Born of Paterson; courtesy membership— Irving G. Larkey, of Passaic.

At the evening session of this part of the Centennial, the members heard an address by T. Duckett Jones, M.D., Assistant Professor of Medicine at Harvard Medical School, on *The Diagnosis and Management of Acute Rheumatic Fever.*

At the afternoon session, Irvine H. Page, M.D., Director of Research at the Cleveland Clinic, Cleveland, Ohio, addressed the County Society on *Modern Concepts and Medical Management of Arterial Hypertension.*

On Wednesday, May 21, at the afternoon session, the subject for discussion was *Practical Problems in Coronary Disease.* Milton J. Raisbeck, M.D., Associate Professor of Medicine, New York Medical College presented a paper on the medical aspects, and Samuel A. Thompson, M.D., Associate Professor of Surgery, New York Medical College, spoke on the surgical aspects of coronary disease.

The two-day Centennial Celebration was climaxed by a dinner at the Alexander Hamilton Hotel, preceding the evening speaker.

Describing the great strides made in the past 12 years in combating hypertension by the use of surgery, Max M. Peet, M.D., of the University of Michigan Department of Surgery, told 250 members of the Society, gathered for the dinner, that he could now almost promise all sufferers of hypertension on whom he operated that they would be relieved of the distressing symptoms of the disease, if not entirely cured. Dr. Peet's address for the evening was *The Surgical Treatment of Hypertension.* Dr. Peet illustrated his talk with slides, which included diagrams, x-rays, charts and graphs, and left little doubt in the minds of those present that, while it is not a cure-all, the use of surgery in hypertension is highly beneficial.

A brief talk was given by Dr. Royal A. Schaaf, State Society President, who eulogized the late Dr. Andrew F. McBride by describing him as "an exemplar of integrity". Also honored by Dr. Schaaf was the late Dr. Elias J. Marsh. The "Elias J. Marsh Oration" was announced by Dr. Schaaf, which will feature the mid-year scientific meeting of the Society in the future.

Dr. Wolfson extended his personal thanks to Dr. Wayne W. Hall, Chairman of the Program and Veterans Committee, and to the Assisting Committee in arranging the Dinner Meeting.

Each speaker illustrated his paper with lantern slides. The papers were excellent and well received, with interesting discussion following the speakers.

AUXILIARY REPORTS

Atlantic County

Mrs. Matthew Molitch,
Chairman, Press and Publicity

A delicious luncheon amid beautiful surroundings was held at the Hotel Traymore on Friday, May 9, to honor the newly elected president of *The Woman's Auxiliary to the Medical Society of Atlantic County,* Mrs. Edward H. Dyer.

The other officers of the Auxiliary for 1947-48 are as follows: President-Elect, Mrs. William O. Roop; First Vice-President, Mrs. Harry Subin; Second Vice-President, Mrs. Louis Rosenberg; Recording Secretary, Mrs. Max Gross; Treasurer, Mrs. Raymond Williams.

The officers were installed by the out-going president, Mrs. Charles Hyman, who wished them success for the coming year. All officers and chairmen of standing committees for the past year gave their annual reports which Mrs. Hyman accepted with thanks. Their cooperation was a big factor in the success of Mrs. Hyman's term of office.

Mrs. Dyer expressed her appreciation to the Auxiliary for the honor which had been bestowed upon her, and assured the membership that with their support, she would endeavor to further the aims of the Auxiliary. She thanked Mrs. Anthony Merendino and Mrs. Max Gross for their efforts in arranging the installation luncheon.

Mrs. Dyer appointed Mrs. Baxter Timberlake Corresponding Secretary, and named the following chairmen of standing committees for the coming year: Arrangements, Mrs. Robert Bradley; Arts, Hobbies and Medical History, Mrs. James Mason; Bulletin, Mrs. William Hersohn; Cheer, Mrs. Samuel Halpern; Historian, Mrs. Hilton Read; Hygeia, Mrs. Morton Major; Legislation, Mrs. Daniel Reyner; Membership, Mrs. Anthony Merendino; Parliamentarian, Mrs. David B. Allman; Press and Publicity, Mrs. Matthew Molitch; Public Relations, Mrs. Ruffin Stamps; Student Nurse, Mrs. Samuel Salasin; Telephone, Mrs. Charles Hyman; Ways and Means, Mrs. Irving Shavelson; Widows and Orphans, Mrs. Abe Krechmer.

The nominating committee for the coming year consists of Mrs. Hyman, chairman; Mrs. J. Carlisle Brown, Mrs. David B. Allman, Mrs. M. B. Holoman, and Mrs. James H. Mason.

Mrs. David B. Allman, First Vice-President of The Auxiliary to the American Medical Association and Convention Chairman, gave an outline of the program for the national A. M. A. convention which will be held in Atlantic City, June 9-12 inclusive.

Camden County

Mrs. Wilmer F. Burns,
Chairman, Press and Publicity

The Annual Inaugural Luncheon of *The Woman's Auxiliary to The Camden County Medical Society* was held at the home of Mrs. Ernest G. Manser, Haddonfield, on May 6.

After the luncheon, Mrs. A. Lincoln Sherk, President, conducted a brief business meeting during which the March card party profit of $690.00 was announced. Upon the recommendation of the Executive Board the members agreed to make the same allotments to the charitable organizations which were aided in 1946.

Mrs. A. Haines Lippincott and Mrs. Arthur G. Pratt gave a resume of the State Convention held in Atlantic City.

Installation of officers for the year 1947-1948 then took place. These are as follows: President, Mrs. Arthur G. Pratt; President-Elect, Mrs. Harold D. Barnshaw; First Vice-President, Mrs. Gerald W. Husted; Second Vice-President, Mrs. A. M. K. Maldeis; Third Vice-President, Mrs. Harold K. Eynon; Treasurer, Mrs. Banks S. Baker; Recording Secretary, Mrs. Thomas K. Lewis; Corresponding Secretary, Mrs. Thomas H. McGlade.

Mrs. A. Haines Lippincott presented the Past-Presidents' pin to Mrs. A. Lincoln Sherk. The gavel was given to Mrs. Arthur G. Pratt who announced her committees for the ensuing year and the meeting was adjourned.

The Program Chairman for the day, Mrs. George B. German, introduced Mrs. Ruth Tomlin of Haddonfield who entertained the group with several amusing reading. Mrs. Harry Fridrich, one of our own new members, rendered several piano selections.

Essex County

Mrs. Ames L. Filippone
Chairman, Press and Publicity

On Monday, April 28, 1947, the *Woman's Auxiliary to the Essex County Medical Society* held a joint meeting with Contemporary of Newark at the Academy of Medicine, Newark. Mrs. J. R. O'Sullivan, chairman of the Health Committee of Contemporary, was in charge. Dr. William D. Crecca, president of the Blood Bank Liaison Committee, spoke on the "Blood Bank". He stressed the urgent need for the Essex county Blood bank, declaring our present supply would be inadequate in case of disaster such as the recent fire in Texas City. He praised the Essex County Board of Freeholders for its cooperation in obtaining legislation for an appropriation for the equipment for the blood bank which is expected will be operating about the end of the year. He also outlined plans for the blood bank which will have its main office at the Newark City Hospital through the cooperation of Director Brady and Dr. Earl Snavely. The Red Cross will open a campaign for blood donors probably a month before the bank begins to function. At least 10,000 pints of blood a year are required for the County.

Mrs. Frank S. Forte, president of the Auxiliary, and Mrs. Ernest C. Reock, president of Contemporary, greeted the audience. A tea followed for members and friends.

Gloucester County

Mrs. Joseph F. Hughes,
Chairman, Press and Publicity

The regular monthly meeting of the *Woman's Auxiliary to the Gloucester County Medical Society* was held on Thursday evening, March 20, at 9 p.m., at the home of Mrs. Harry Nelson, Woodbury. There were 13 members present. Mrs. Fred Faux, chairman of the nominating committee gave the following report: President, Mrs. C. I. Ulmer, Gibbstown; President-Elect, Mrs. David Brewer, Jr., Woodbury; Retaining Vice-President, Mrs. Paul Pegau, Woodbury; Retaining Secretary, Mrs. Louis Collins, Glassboro; Retaining Treasurer, Mrs. George Booth, Westville. The delegates and alternates were appointed for the 20th Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey, to be held in Atlantic City, April 22, 23 and 24. They were Mrs. Clarence Bowersox, delegate, Mrs. Paul Pegau, alternate; Mrs. B. A. Livengood, delegate, Mrs. David Brewer, Jr., alternate; Mrs. A. G. Campo, delegate, Mrs. R. K. Hollinshed, alternate.

It was decided to use the funds now being raised by a series of card parties for the purchase of automatic record players for Tilton General Hospital, Fort Dix. There is a greater need for these instruments than for microfilm libraries, the purchase of which was originally planned. The first card party for this purpose was given by Mrs. Louis Collins and Mrs. William Pedrick, of Glassboro, on March 14, at the home of Mrs. Collins. Mrs. C. A. Bowersox, Mrs. Harry Nelson and Mrs. Ralph Moore held one on March 25, at the home of Mrs. Bowersox, in Woodbury.

Middlesex County

Mrs. Norman Rosenberg,
Chairman of Press and Publicity

Judge Libby Sachar of Plainfield spoke on "Delinquent Parents" at a meeting of the *Woman's Auxiliary to the Middlesex County Medical Society* which was held at the home of Mrs. Nathan Gorog of River Road, Highland Park on Wednesday, April 16, at 8:30 p. m. Judge Sachar claimed that the basis of delinquency is insecurity, economic and psychologic. Society is facing a crisis, she said, with the marked increase in delinquency. Instability in the structure of family life is responsible.

During the business meeting, Mrs. M. S. Brody, Mrs. L. A. M. Feher and Mrs. C. F. Merrill were chosen as delegates to the state convention in Atlantic City on April 22, 23 and 24; Mrs. William Stein was appointed chairman of the annual luncheon which will be held at Oak Hills Manor, Metuchen, on May 21. Old and new state presidents will be guests.

Co-hostesses were Mrs. John Van Mater, Mrs. Samuel Lavine and Mrs. Solomon Goldman.

Monmouth County

Mrs. Joseph E. Bossone, Chairman of Publicity

The Woman's Auxiliary to the Monmouth County Medical Society held its monthly luncheon meeting at the Willow Brook in Fairhaven, Tuesday, March 18. Mrs. Victor Siegel, Red Bank, was hostess, and Mrs. Norman Nathanson presided.

The nominating committee submitted their selection for officers for the coming year to be voted on by the Auxiliary at the next meeting and to be installed in office at the May meeting.

Mrs. Maxwell Colby, chairman of constitution and by-laws committee, submitted the new constitution and by-laws drawn up by the committee for the approval of the Auxiliary members. Copies will be printed and mailed to all members.

Mrs. Stephen Casagrande, chairman of the dinner dance for the Medical Society which was held on the 15th, reported a grand success. Over one hundred guests attended.

Mrs. Robert McTague of Highlands, will be next month's hostess, when a luncheon will be held at The Log Cabin, Highlands.

Ocean County

Mrs. Harvey Rinzler, Publicity Chairman

The *Woman's Auxiliary to the Ocean County Medical Society* held this year's final meeting at the Lakewood Country Club on June 7, to install the following officers for the coming year: President, Mrs. Raymond Taylor; 1st Vice-President, Mrs. Carmine Pecora; 2nd Vice-President, Mrs. Bruce Hendrikson; Secretary, Mrs. Norman Szold, and Treasurer, Mrs. Adolph Towbin.

Mrs. Raymond Taylor appointed three of her committee chairmen: Legislation, Mrs. Carl Menge; Publicity, Mrs. Harvey Rinzler, and Public Relations, Mrs. Abraham Goldstein.

Passaic County

Mrs. Irving Silverman,
Press and Publicity Chairman

The Woman's Auxiliary to the Passaic County Medical Society held its regular meeting on March 7, at the home of Mrs. Joseph R. Jehl, in Clifton. Mrs. Albert Markel presided.

Reports were given by the following chairmen: arts and hobbies, Mrs. Irving Hayman; public relations, Mrs. Paul Rauschenbach; cancer, Mrs. Harry Gochman.

Mrs. Theodore Bender was introduced as a new member by the president.

Mrs. Markel appointed the following delegates to the convention of the State Auxiliary to be held in April in Atlantic City: Mrs. Joseph Mott, Mrs. Richard J. McDonald, Mrs. P. J. DeBell, Mrs. Joseph R. Jehl, Mrs. E. J. Hatem, Mrs. W. W. Weintraub.

Alternates are: Mrs. William Morrocco, Mrs. Henry Bongiorno, Mrs. A. D. Meneve, Mrs. Nicholas Scielzo, Mrs. Julian Cohen and Mrs. D. A. Wry.

The president also announced the honor to the County Auxiliary by the appointment of Mrs. Joseph E. Mott, state legislation chairman and past president of the County Auxiliary, a delegate from the state auxiliary to the convention of the American Medical Association to be held in June at Atlantic City.

Mrs. P. J. DeBell, program chairman, introduced the speaker of the day, Mrs. Emma D. Howe, supervisor for the Commission for the Blind of New Jersey, who gave an excellent account of the work being done by the group.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **July, 1947** **No. 7**

PHYSICIANS have long observed that tuberculosis attacks the upper lobes of the lung by preference. A physiological explanation for this fact has been advanced. This hypothesis, if accepted generally, would put the standard treatment for tuberculosis—bed rest—on a sound scientific foundation, and mark a significant advance in our knowledge of infection and therapy in tuberculosis.

APICAL LOCALIZATION OF PHTHISIS

No discussion of human tuberculosis and its management is complete or convincing unless it takes into account the fact that, in its inception and throughout much of its course, phthisis in adults is confined to the upper third of the lungs. Most members of white and many members of yellow racial groups are almost immune to tuberculosis except in this region. It is a remarkable fact that, even after the sputum and gastric washings contain bacilli consistently, pulmonary lesions for years may be limited to the upper third of the lungs.

Explanations of this curious predilection for the apex have been unsatisfactory. Those who have most consistently urged bed-rest for the treatment of phthisis seem unconcerned with the apical localization and its significance in the pathology and therapy of tuberculosis.

The relation of man's erect posture to the physiological functioning of the lung is usually ignored. Recently published data on blood pressures in the right ventricles of human hearts show that when a tall, long-chested individual is standing or sitting the pressure of the column of blood from the right ventricle to the apex of lungs is equal to or greater than the mean arterial pressure in the pulmonary arteries. Thus the flow of arterial blood will be greatly restricted or even absent at the apices of the lungs of most adults while they are in the erect posture. Nor at such times is tissue fluid or lymph produced by filtration in this area, since it requires nearly 15mm. Hg pressure to overcome the difference in osmotic pressure between the plasma and the pulmonary tissue fluid.

As a result of the decreased flow of blood addition of carbon dioxide to and removal of oxygen from alveoli in the apical region will be minimal. Tubercle bacilli reaching this tissue will be in an optimal atmosphere to support their metabolism although this is probably not an important factor in apical localization.

As long as the subject is sitting or standing, the pulmonary arteries can bring few antibodies to the apical region and removal of bacterial products by lymph, or dilution by diffusion into the blood will be almost nil. Only when the patient is recumbent will these tissues be protected against accumulation of toxic substances. Removal of bacteria to the lymph nodes will be suspended during most of the waking hours, as will the replacement of antibodies and of monocytes from the blood.

In view of these facts, it is not remarkable that active tuberculosis so regularly begins in this region, or that it shows a predilection for the tall, long-chested individual and the lively young people who get a minimum of sleep. Lack of rest is important in that it gives the bacilli the maximal number of hours of optimal growth conditions and the tissues the minimal number of hours when the neutralization and dilution of toxic products, and the supply of antibodies and blood-borne phagocytes are as adequate at the apices as elsewhere in the lungs.

The great frequency of silicotic lesions at the apex also may be due to the fact that dust particles reaching this region will be removed by phagocytes less rapidly, and the injurious substances will be

diluted and removed more slowly than in other parts of the lung.

This explanation of apical susceptibility is borne out by the statistics on the relationship of pulmonary tuberculosis and heart disease. Where the pulmonary circulation is depleted, as in cases of pulmonic stenosis, the incidence of active tuberculosis is high. Where there is pronounced mitral stenosis and the pulmonary circulation is engorged, cases of pulmonary tuberculosis are a rarity. This is not a matter of academic interest only. If the explanation given above is correct, obviously the ideal treatment of the early apical lesion is complete recumbency for most of the 24 hours. Clinicians who insist on "complete bed-rest" should realize that propping the patient up in bed for more than half an hour at a time interferes with the correct postural management.

So long as bed-rest remains an empirical and nonspecific form of therapy, it will be difficult to enforce it on intelligent people who feel well. An understandable, physiological explanation will make their cooperation more certain. To every adult with an apical lesion the hazards of the erect posture and the value of recumbency should be stressed. However, complete bed-rest, with its attendant discomfort and higher cost of nursing care, may not be superior to many hours of recumbency with brief periods out of bed.

Prolonged bed-rest will be better borne if numerous and gradually lengthening periods of sitting up or strolling about can be alternated with recumbency. A consideration of the pathogenesis of the apical and subapical lesions suggests that this may be sound practice in patients not prostrated by disease.

Apical Localization of Phthisis, William Dock, M.D., American Review of Tuberculosis, April, 1946.

POSTURAL FACTORS IN APICAL TUBERCULOSIS

The theory that apical tuberculosis is due to postural ischemia accounts for its frequency in those young adults, studious or playful or both, who get little rest and are continuously erect 14 to 20 hours daily. If accepted, this theory also explains why bed-rest alone is effective in so many of these cases but of much less value in those with pulmonary basal lesions or tuberculosis of the kidney, epididymis or skin. When patients are propped up in bed to read, ischemia of the apex is not abolished. The effectiveness of bed-rest is thus greatly increased by outdoor exposure during the day, as the breezes and bright light discourage reading and promote appetite and sleep by stimulating the skin and tiring the eyes. Where patients are outdoors during the day they spend the maximal number of hours quiet and completely recumbent. However, it seems not impossible that brief intervals out of bed for meals and to facilitate nursing would not unfavorably affect the "cure" and make it less demoralizing and costly.

The new understanding of apical tuberculosis will make such therapy as complete recumbency easier for patients to accept. While awaiting specific antibiotics capable of controlling this disease, physicians will welcome a reasonable explanation for the pathogenesis of apical tuberculosis and for the therapeutic method which is still the main reliance in dealing with the commonest cause of prolonged disability and of death among young adults.

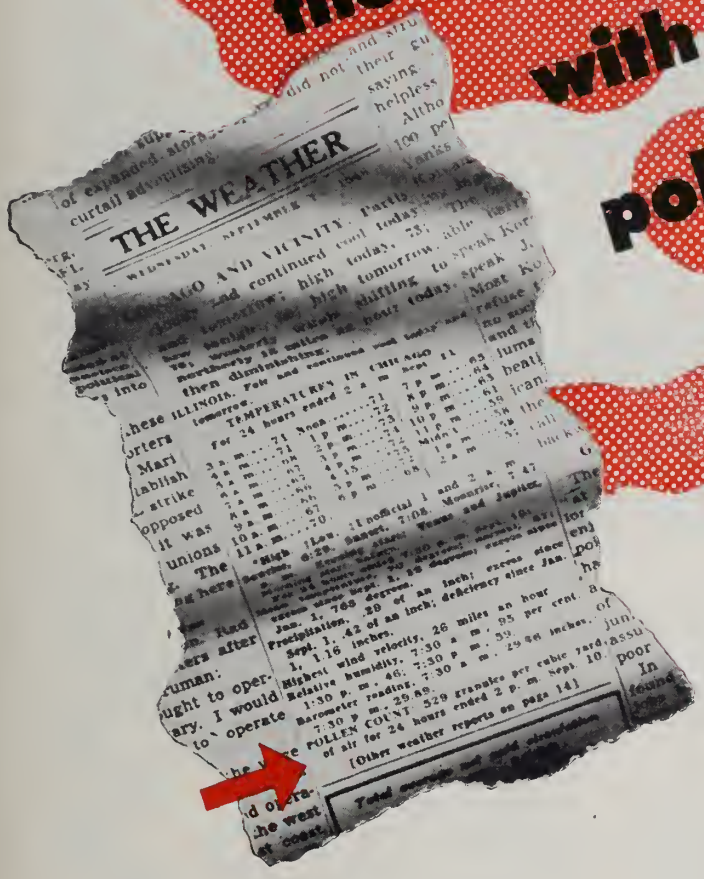
Editorial, Journal of the American Medical Association, July 13, 1946.

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[1]Human Fertility 10: 25 (Mar.) 1945.

[2]Warner, M. P.: J.A.M.A. 115: 279 (July 27) 1940.

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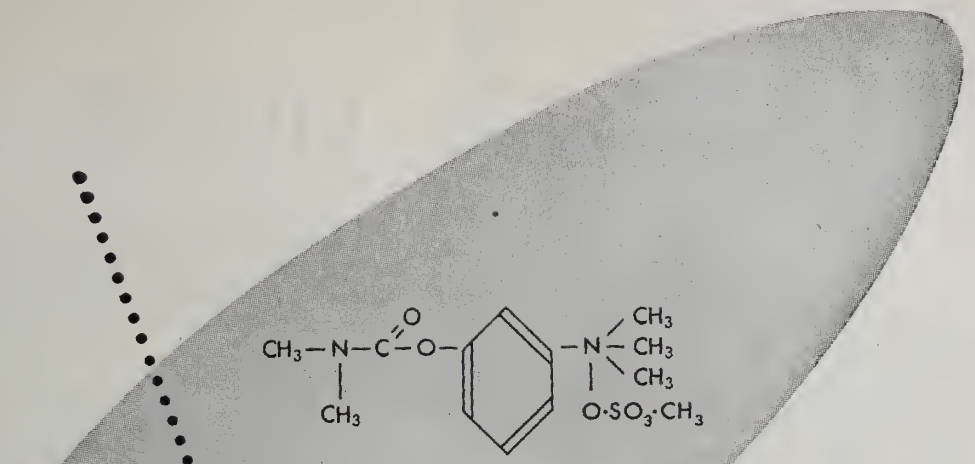
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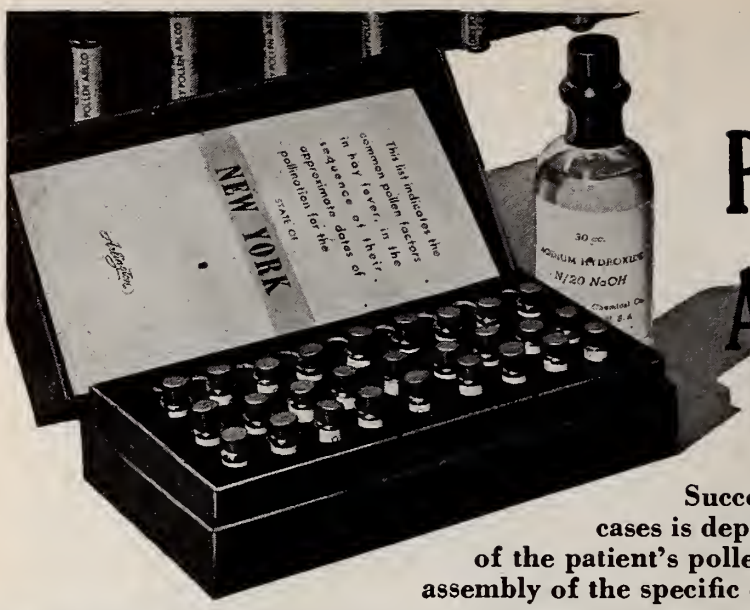


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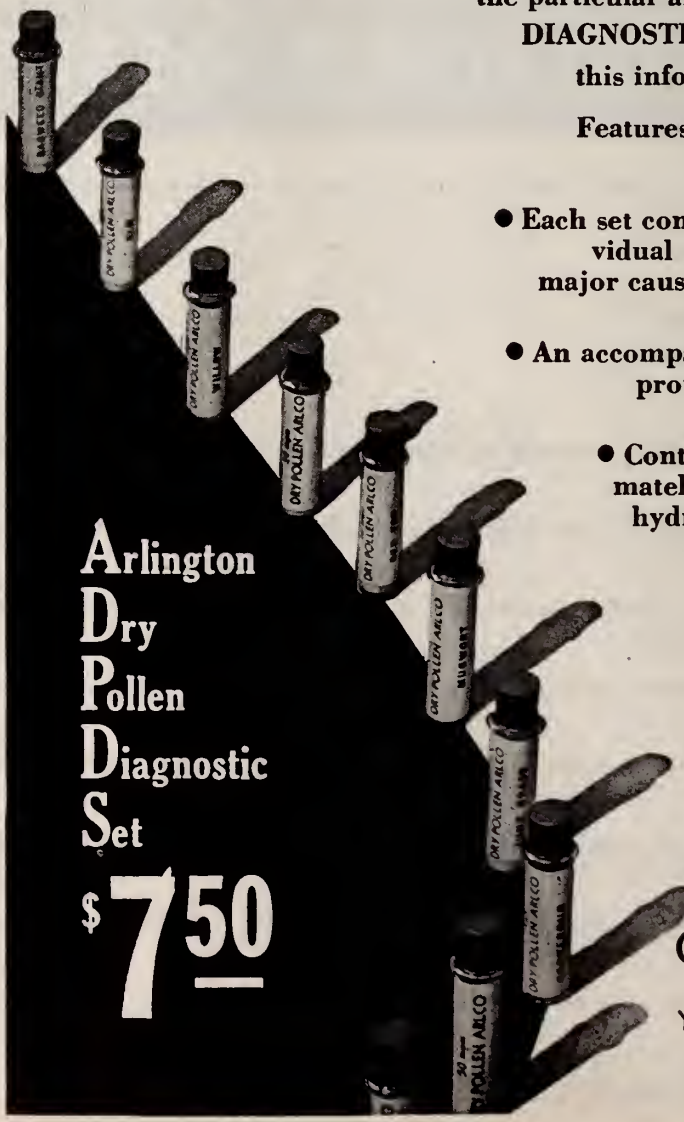
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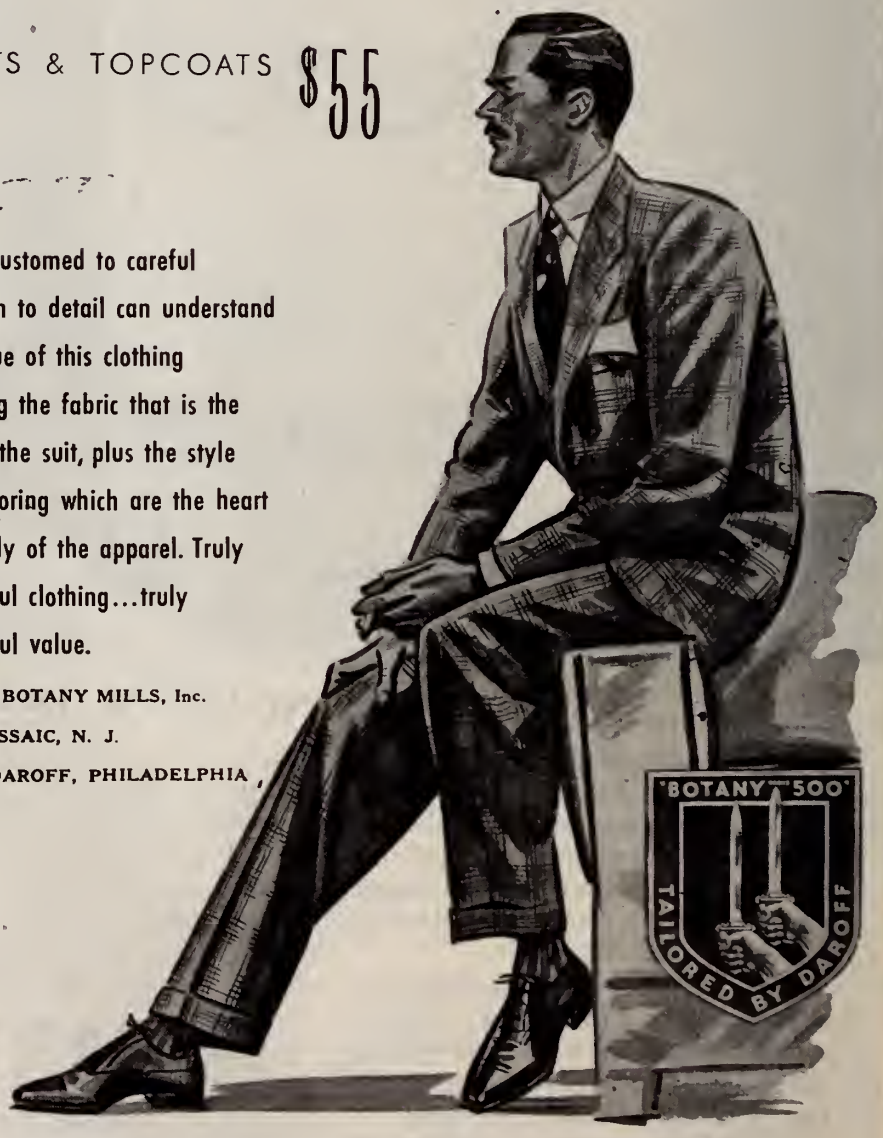
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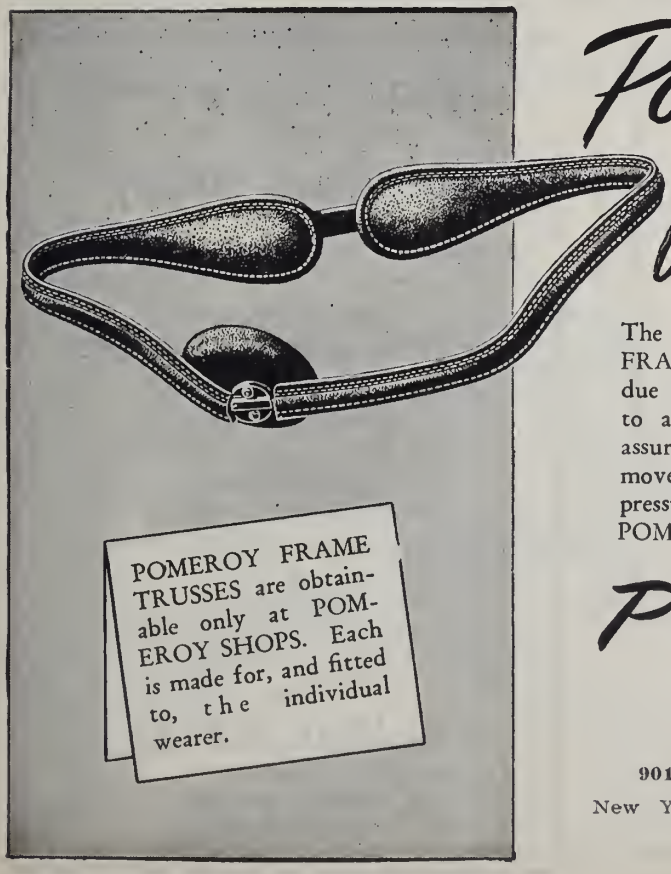
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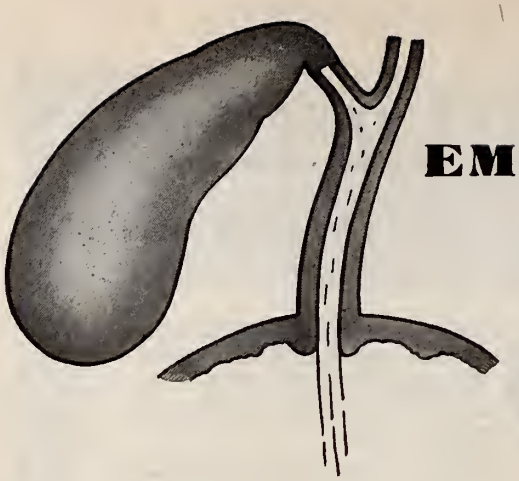
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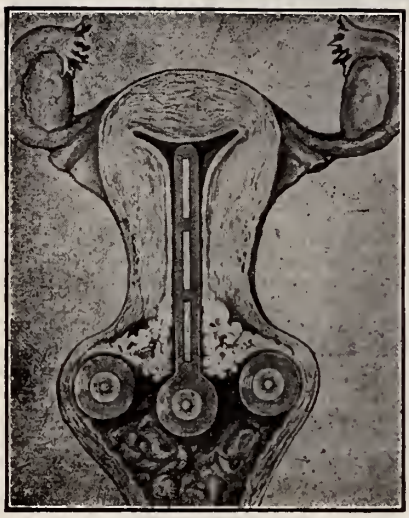
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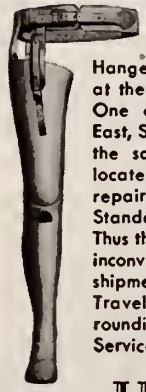
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OF

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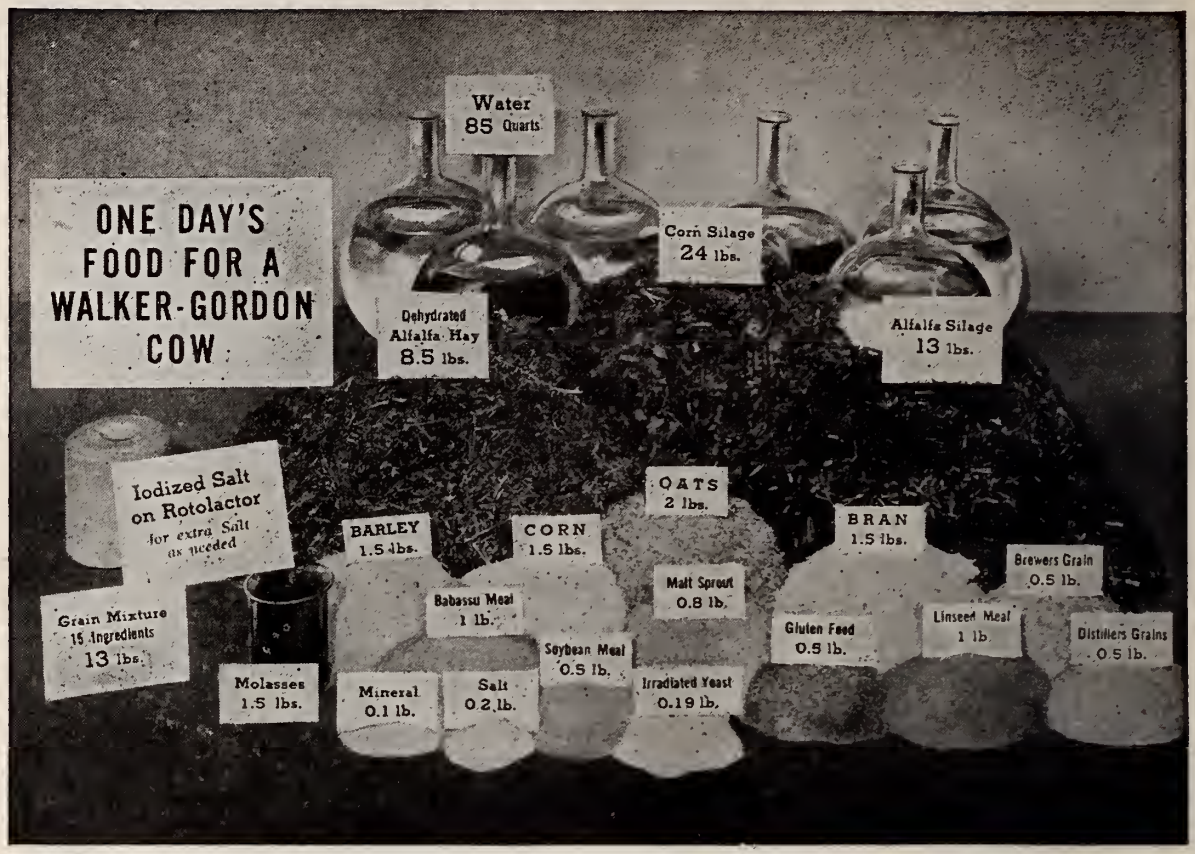
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In discovering this offending substance (known as an allergen), your doctor acts as a detective. He may ask detailed questions about the time of your attacks, where they occur, the furnishings of your home, the food you eat.

Such questions may give him clues to the nature of your trouble. If your attacks come, for instance, in the late spring or summer months and last till the first frosts, he will suspect that your trouble is due to some pollen, that you may have some form of "hay fever."

In other forms of allergy, it is not so easy to track down the offending substance. If your case is not clear-cut, your doctor must consider hundreds of possibilities.

A few grains of mustard can make some people violently ill. A man can be sensitive to his wife's face powder, or to dog hair, or grass pollen, or to the cattle hair in the mat under a rug.

Simple skin tests are often used to reveal the offending substance. Drops of various extracts—of pollen, foods, and other substances—are injected into the skin or put on skin scratches. If you are sensitive to the substance being tested, a swelling will usually develop within a few minutes.

Once a doctor has found what causes the allergic reaction—by means of the history of the case supplemented by skin tests—he will prescribe treatment according to the nature of the patient's sensitivities.

If the patient is allergic to a particular food, the easiest solution is to avoid the food. If his sensitivity is to feathers, the substitution of a fibre pillow for a feather one may bring surprisingly effective relief.

If the allergen is house dust or pollen, or something else that cannot be easily avoided, a series of inoculations may be suggested.

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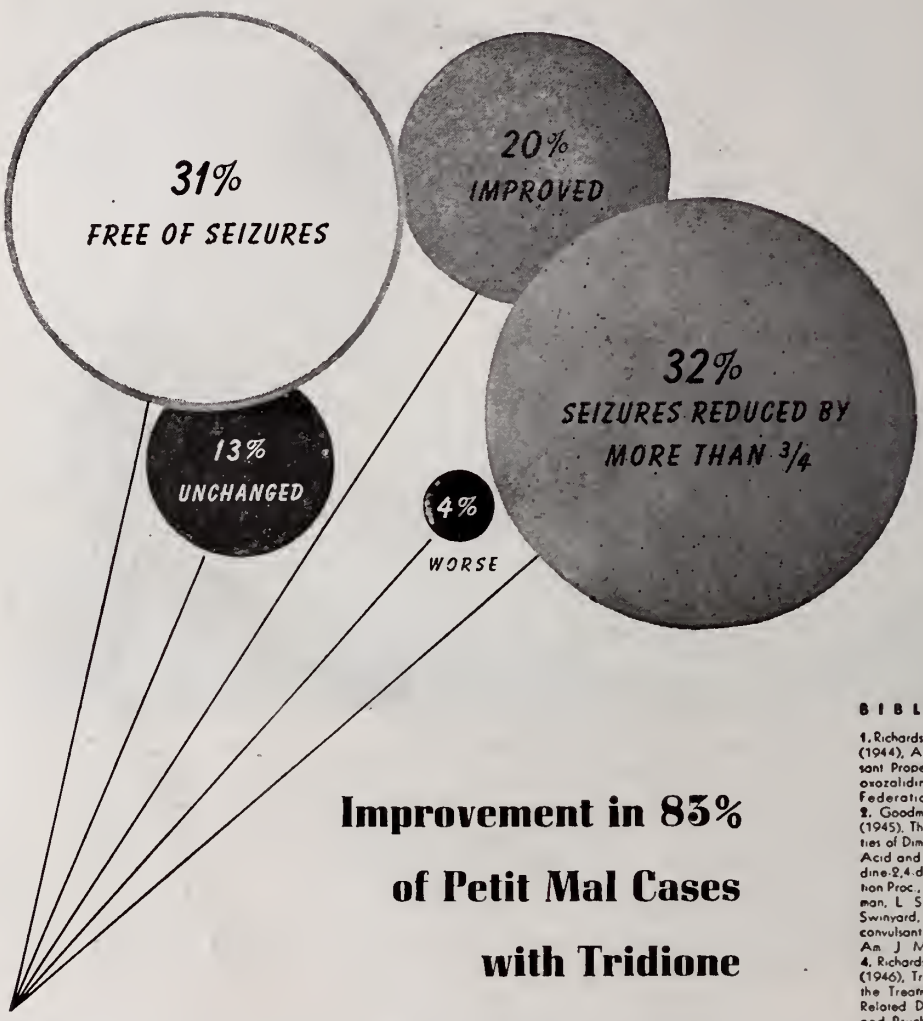
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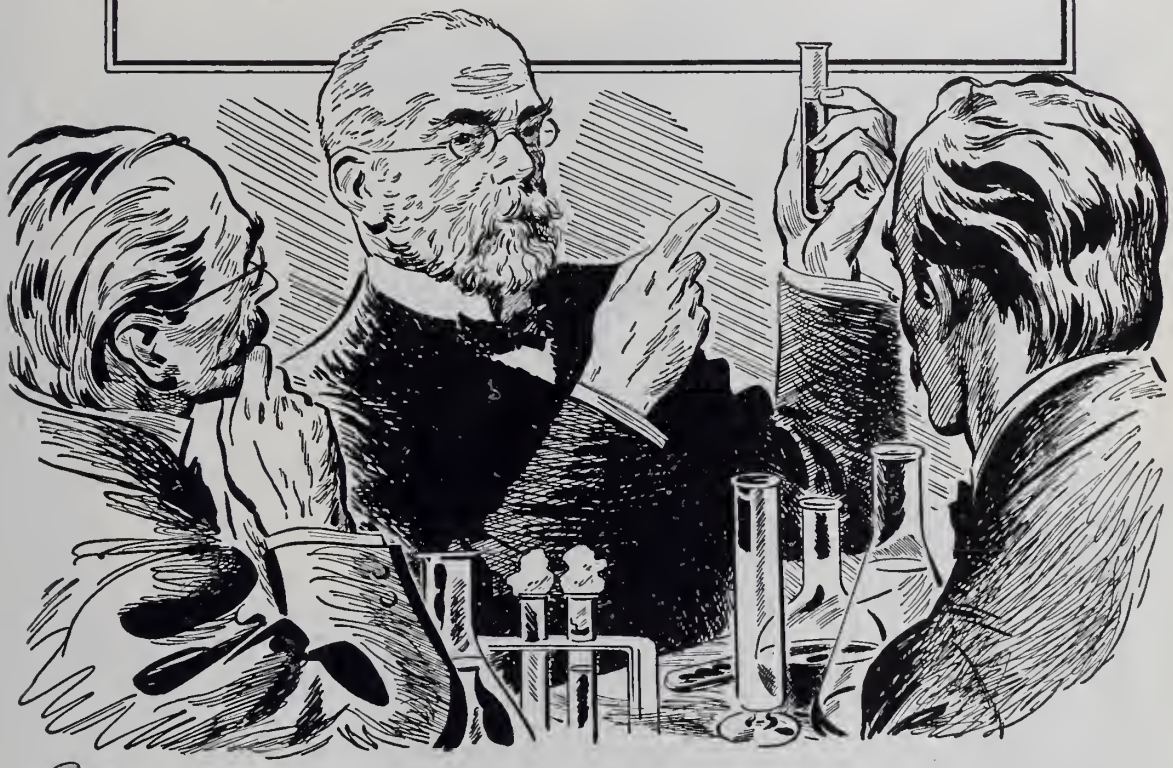
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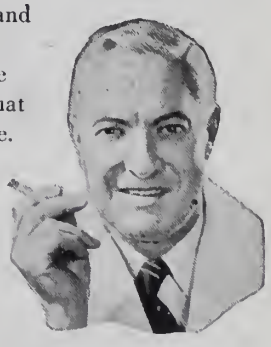




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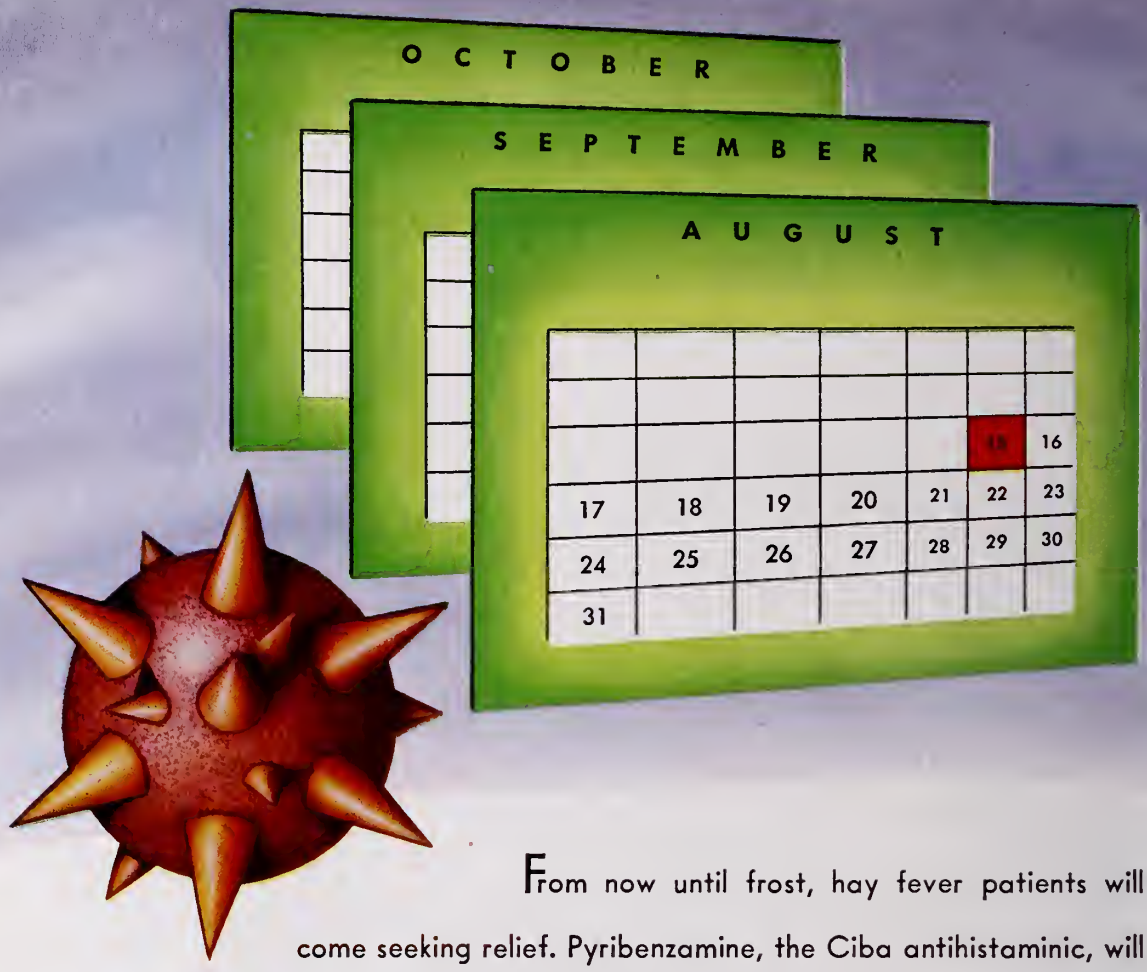
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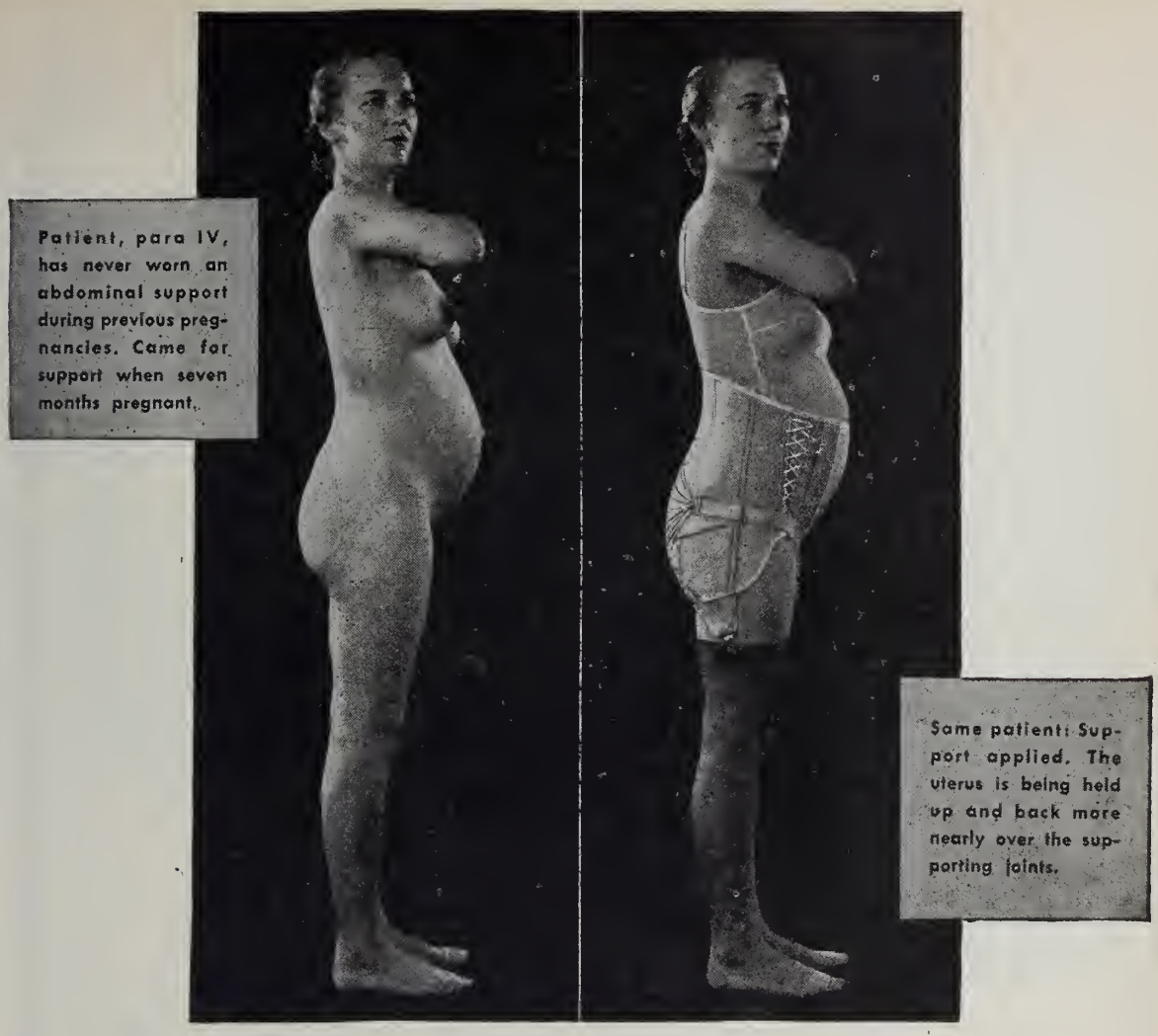


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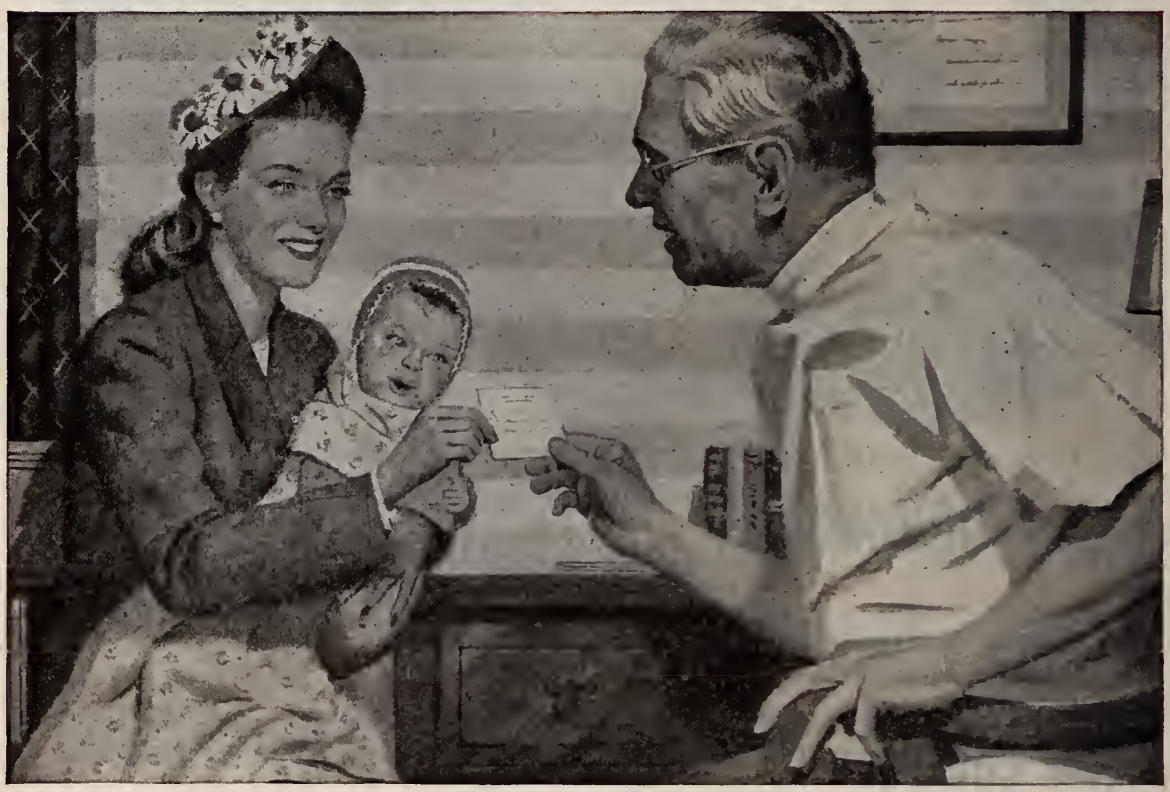
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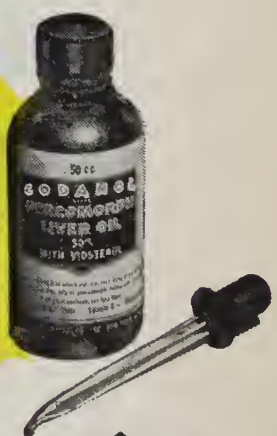
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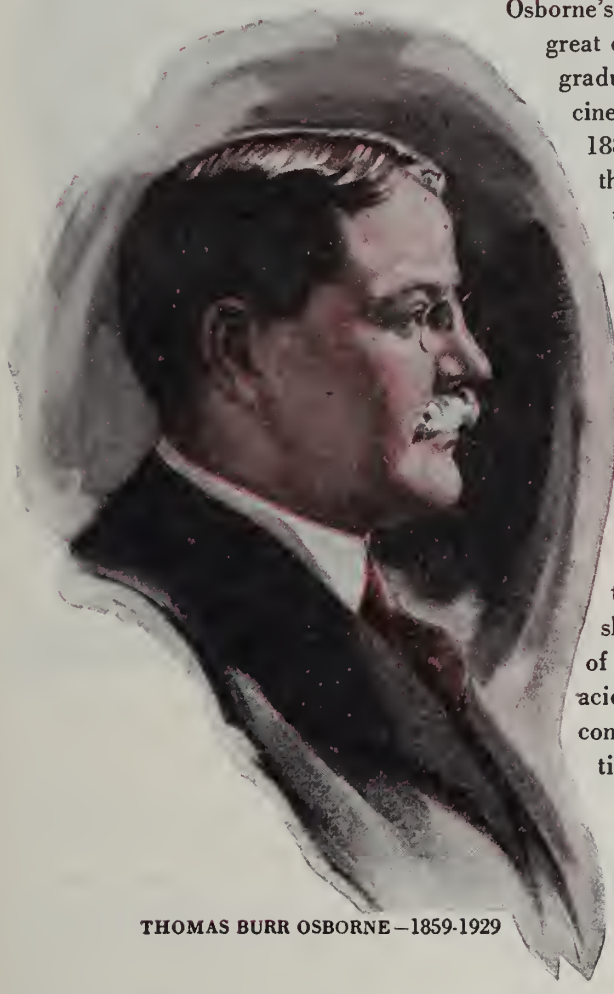
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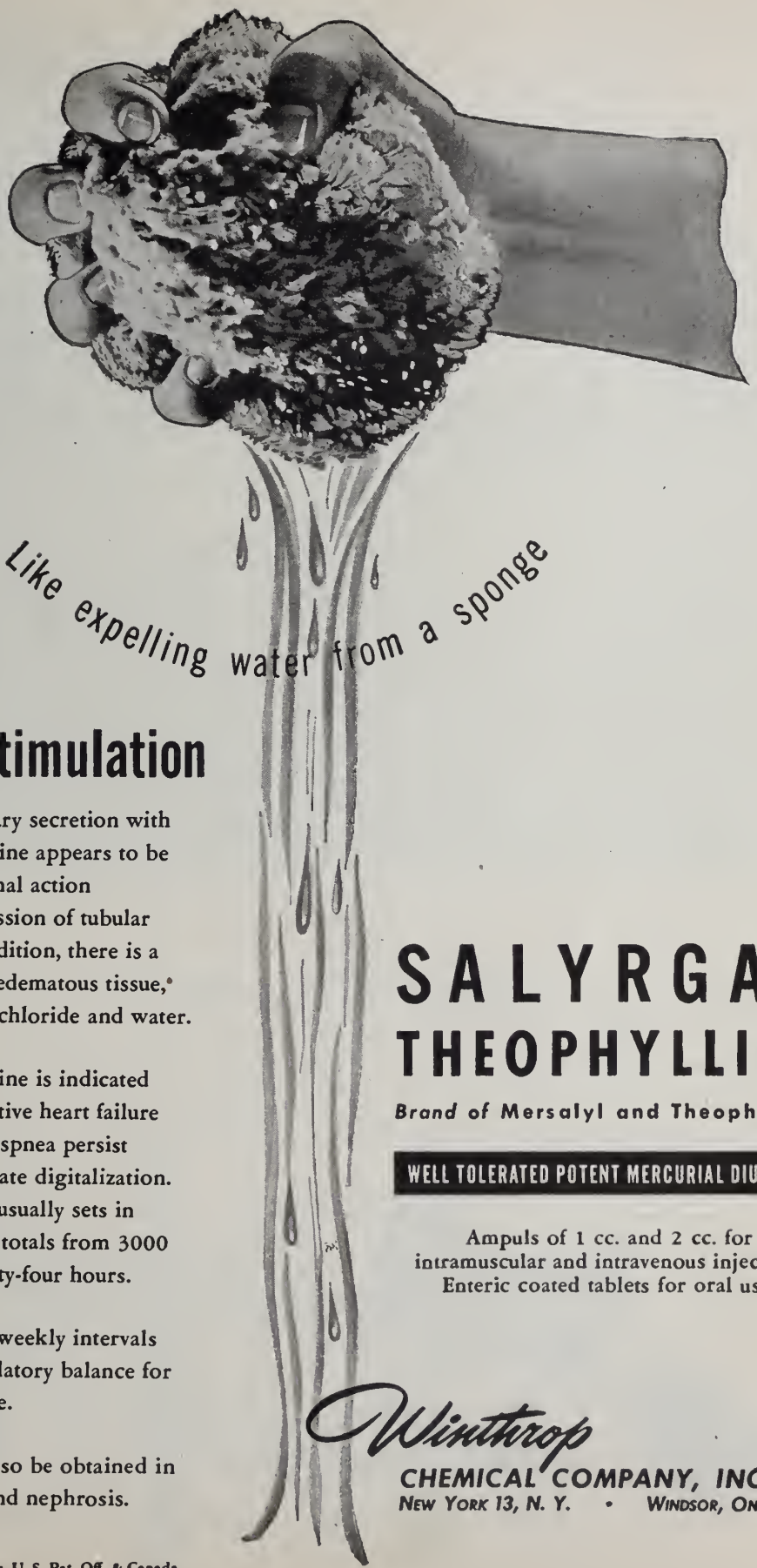


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1. Youmans, J. B.: Virginia Med. Monthly, 72:238, June, 1945

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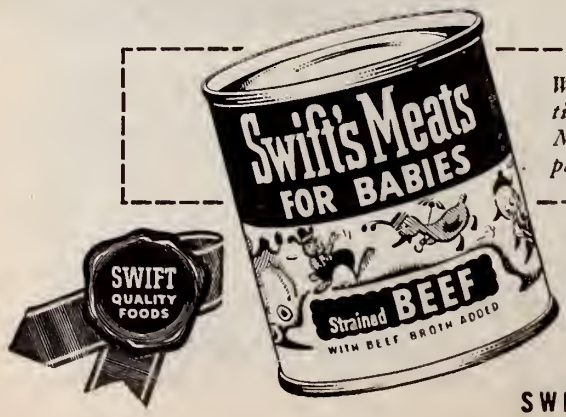
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Riddle of the Swamps

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Henry C. Barkhorn, M.D.,
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Henry A. Davidson, M.D., Editor

Miriam N. Armstrong,
Assistant Editor

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THE PRESIDENT'S PAGE

THE NEW EXECUTIVE OFFICER

Prior to 1890, the function of The Medical Society of New Jersey was almost entirely scientific, with a dash of sociability to "leaven the loaf". With the increase in our knowledge of the etiology and prevention of communicable diseases and the advent of organized public health projects, such as the control of tuberculosis, typhoid fever, contagious diseases, and the like, our Society became the agency for the practical implementation of group health programs. We became a public health body. In 1910 or thereabout, we began to interest ourselves actively in state legislation having public health or medical practice implications — workmen's compensation, osteopathy, chiropractic, etc.—supporting those measures which appeared to us to be in the public interest and opposing those which seemed not to serve that interest. Our efforts invariably were aimed at serving the general welfare rather than



James E. Bryan

New Executive Officer of The Medical Society of New Jersey

our own selfish professional group advantage.

The economic aspect of medical practice was a taboo subject for state or county medical society discussion until the widespread depression of 1929 and subsequent years gave impetus to the movement to socialize medicine in this country. This compelled organized medicine to study the problem of the distribution of medical care for the purpose of bringing adequate medical care to all of our people without destroying the existing form of medical practice which has flourished so bountifully under the system of private enterprise.

To counter the barrage of criticism of the medical profession and organized medicine laid down by social workers, economists (?), government administration, politicians (?) and "do-gooders" of various colors, it became necessary for us to develop a public relations program by means of which we could present to the people the accomplishments of American medicine in the past, its present status and its future possibilities; the factors involved in the economics of medical practice, and the arguments by which we hoped to confound the proponents of socialized medicine.

Public Relations is a comparatively new development in present day living. It is as much a profession as teaching or banking and it requires as much training and experience as any other type of business administration.

At the present time, the major activities of The Medical Society of New Jersey are (1) legislation (2) distribution of medical care (3) the Veterans' Medical Care Program and (4) public relations. Legislation is being efficiently cared for by a subcommittee under Dr. Pollak with Dr. Quigley as Executive Secretary. The distribution of medical care is being conducted very satisfactorily by the Medical Service Administration and the Medical-Surgical Plan, with Dr. Scott as their Medical Director. The Veterans' Medical Care Program is being managed as well as could be hoped for by the Central Veterans Liaison Committee under the able direction of Dr. Londrigan with Dr. Yorke as our full time liaison officer.

Beginning September 1, 1947, our Public Relations activities will be conducted by our new Executive Officer under the general direction of the Subcommittee on Public Relations, with Dr. Sica as Chairman. Our Society is indeed fortunate in having found Mr. James E. Bryan after a long and discriminating search. He comes to us with fourteen years of training and experience in county medical society administration, especially in the editorial and public relations fields. He is an indefatigable worker possessing intelligence, resourcefulness,tact, geniality and friendliness. He is exceptionally well qualified to serve as our contact man with lay organizations, both government and private. He will fill the void caused by the death of Dr. Wilkes, who was so capable in this work, and he will reestablish many of the cordial relationships with these important groups, which unfortunately and unavoidably lapsed following our loss of Dr. Wilkes.

Mr. Bryan will have many and varied functions, some of which are not yet clearly defined, not the least of which will be the building up of a closer liaison between the State Society and its component county units.

To those of our members who entertained serious doubts as to the advisability of placing the conduct of our administrative affairs in the hands of a layman rather than a physician, it should be pointed out that with four exceptions, executive officers of all state medical societies today are laymen who are apparently serving in an eminently satisfactory manner.

With the addition of Mr. Bryan to our executive staff, our members may confidently expect increased administra-

tive efficiency with consequent greater benefits to the general public as well as to ourselves.

Mrs. Madden has rendered yeoman—or should I say yeomanette—service to The Medical Society of New Jersey for the past five years in the capacity of Acting Executive Officer. She will continue to conduct the internal affairs of the Society as she has in the past but will be relieved of the burden of Public Relations work and extramural activities which will be assumed by Mr. Bryan.

I wish at this time, on behalf of the Trustees and Members of The Medical Society of New Jersey, to express to Mrs. Madden publicly our deep appreciation of the invaluable service which she has rendered to us.

ROYAL A. SCHAAF, M.D.
President.

A FEDERAL HEALTH DEPARTMENT

Since 1844 the organized medical profession has been urging Congress to establish a department of health, with cabinet status. Bills have occasionally been introduced which would merge health and welfare activity or (as in the current S. 712 for example) health, education and social security. The consolidation of health functions with social security, public welfare or national education is a favorite project with many civic groups. On the face of it, the proposal does not seem unreasonable. No one denies the relationship between poverty and illness; no one doubts that our health resources would be better used if the public were educated to their better use. Thus a *prima facie* case can be established for the union of health and welfare functions. However, the same reasoning could be used to justify placement of a health agency in the Department of Agriculture (because health is related to food) or in the War Department (because health is related to national defense) or indeed into almost any cabinet department, since without good health, no personnel will function efficiently.

Objections to merging health and other welfare administration are less obvious but more compelling. Experience indicates that when medical activities are yoked with other functions, administration tends to vest in nonmedical personnel. One of the objections to the medical program of the Veterans Administration, in the days before its rejuvenation, was that all medical functions were in the department that administered insurance, so that the chief medical officer had no direct access to the Administrator. Net result was a subordination of medical activities and a demeaning of medical personnel. In a department combining say, medical and social-security activities, who would be the top administrator? Few doctors claim any special skill in administering a complex social security program with its numerous problems in actuarial statistics, employment finances and the higher economics. As a result, the chief administrative post is likely to go to some nonmedical person versed in these economic, actuarial or sociologic skills.

It is good to know that national officials are giving thought to the welding into a single unit of the scattered civilian health functions of the federal government. It would be still better news to learn that these activities will be placed where they belong, under the jurisdiction of a doctor of medicine.

ORIGINAL ARTICLES

THE SURGICAL TREATMENT OF CONTINUED HYPERTENSION *

SOME SUGGESTIONS ABOUT THE SELECTION OF CASES FOR THIS FORM OF THERAPY

By REGINALD H. SMITHWICK, M.D., Boston, Massachusetts

This communication is based on a study of early results in 439 unselected hypertensive patients treated by extensive sympathetic denervation of the visceral vascular bed and followed from one to five or more years. The data have been reviewed in an effort to determine the circumstances under which this form of treatment is most effective. Two previous analyses [1,2] have been made of 156 patients followed for shorter periods of time. Enough cases have now been observed for an adequate period to indicate that surgery in many hypertensive patients is a useful and worthwhile addition to the armamentarium available for this disorder. Sufficient time, however, has not elapsed to make a final evaluation of this treatment. Because of increasing and widespread interest in the possibilities of surgical therapy, this discussion is offered in the hope that it will be of help in the selection of patients who are most likely to benefit from treatment of this sort.

PURPOSE OF SYMPATHECTOMY

The purpose of sympathectomy is to decrease the peripheral resistance to blood flow through a large portion of the vascular bed. Hypertension is generally regarded as the result of increased peripheral resistance to the flow of blood through the arterioles in particular; and many possible causes have been suggested. These may be divided into two main categories, (a) physiologic and (b) organic.

Physiologic causes of increased peripheral resistance are those which may result in constriction of the arterioles. These are either neurogenic or humoral. By "neurogenic" is meant vasoconstriction resulting from a nervous impulse which stimulates vascular smooth muscle either intermittently or continually or both. By "humoral" is meant vasoconstriction resulting from a direct action of circulating substances upon smooth muscle which is entirely independent of the nervous system and which is separate and distinct from the action of the chemical substances presumably elaborated as the result of nervous impulses and which are thought to be the effective mediators of vasoconstriction of neurogenic origin.

Organic disease of the arterioles theoretically can cause increased peripheral resistance to blood flow and is known to be wide-spread in hypertensive patients particularly in the late stages of the disorder. An excellent description of the pathologic changes in hypertensive patients, dying of some complication of the disorder, has been presented by Moritz and Oldt.[3]

It is theoretically possible that all three causes,—nervous, humoral and organic, could be in operation at the same time. Current opinion [4] favors a primary nervous mechanism followed by humoral mediators of vasoconstriction and by organic vascular disease. However, opinions have varied widely in recent years,[3,5,6] and no doubt will continue to do so for some time. In any case, all the possible causes of increased peripheral resistance might coexist. If all three were operating at the same level, the removal of any one would not be effective. If one mechanism is dominant and can be modified, the peripheral resistance should decrease, at least to the level at which other causes of increased peripheral resistance are operating. In their absence, blood pressure should return to normal, that is, to the level of peripheral resistance due largely to the nor-

* Read by invitation, May 22, 1946, before Annual Meeting of The Medical Society of New Jersey.

mal or intrinsic tone of the vascular smooth muscle. The purpose then, of sympathectomy is to reduce that portion of the peripheral resistance which may be caused by intermittent or continued neurogenic vasoconstriction. The hope is to prolong life, to make living more worthwhile, and (by lessening the severity of the hypertension) to cause the regression of, or to slow or arrest the progress of, organic cardiovascular disease and its fatal complications: heart failure, cerebral accidents, and renal failure. It seems probable that much of the vascular disease which exists at death develops *after* the onset of the hypertension. Biopsy material taken at the time of operation [7] suggests that this is the case. Also, favorable changes in eyegrounds, electrocardiograms, heart size, and kidney function, which frequently occur when the severity of the hypertension is lessened, all favor the concept that the hypertension itself is responsible for much of the subsequent cardiovascular damage. Hence, attempts to reduce blood pressure by decreasing the peripheral resistance, through the arteriolar bed, seem logical, particularly if made before cardiovascular damage is too advanced. My experiences over the past thirteen years suggest that a favorable modification of hypertension, which for the period of observation appears to be worthwhile, has occurred in approximately two-thirds of unselected surgically treated patients. In one third, the results are equivocal or obviously not worthwhile. It is apparent, therefore, that an attempt should be made to perfect the selection of cases for this form of treatment.

NATURE AND EXTENT OF OPERATION

The operation which has been performed in this series of 439 cases was first described [8] in 1940, and has been called lumbodorsal (thoraco-lumbar) splanchnicectomy. It was designed thoroughly to denervate the visceral vascular (splanchnic) bed. It is tantamount to a combination of the subdiaphragmatic splanchnicectomy of Craig [9] and Adson,[10] and the supradiaphragmatic procedure of Peet.[11,12]. It was developed as the result of multiple stage operations in a small series of patients in whom lesser procedures had failed to modify the hypertension, or in some instances where a successful original operation had been followed by recurrence of hypertension, presumably due to regeneration of vasoconstrictor fibres. By extending the initial procedure in those cases so that the final maneuver included the lower thoracic and upper lumbar ganglia it was found that about 30 per cent of failures were converted into worthwhile results. This suggested that the statistical chances of a higher ratio of satisfactory results would be increased by extending the primary operation somewhat, and that the danger of regeneration would then be reduced. A series of 26 unselected cases was then operated upon in two stages by the lumbodorsal technic and early results [13] indicated that 65 per cent were improved. This percentage has continued to hold through subsequent series including the present group of 439 cases.

In brief, a paravertebral incision is made extending from the ninth rib to the iliac crest. Portions of the eleventh and twelfth ribs are resected, the diaphragm divided and the sympathetic trunk removed from the eighth thoracic to the first lumbar ganglia inclusive, sometimes including the second and third lumbar ganglia as well. The great splanchnic nerve is resected from the celiac ganglion to the mid-thoracic level. This exposure permits careful inspection of the kidney and adrenal. Biopsies of the kidney have been taken for study and adrenal tumors removed when present. Although tumors of the adrenal gland are infrequent, they should not be overlooked as they are occasionally important factors in the hypertensive state. Their presence is, for the most part, unpredictable; consequently any operation for hypertension should permit adequate exposure of this area.

The operation is performed in two stages, eight to ten days apart and has been described in greater detail elsewhere.[8,13,14,15] In unselected cases, operative mortality has been 2.4 per cent; and it should be less than one per cent in selected cases.

Period of hospitalization is approximately 30 days, and in addition two to four months' convalescence after leaving the hospital is usually necessary. Duration of this period de-

pends on the degree of postural hypotension present in the acutely denervated state. This varies with the downward extent of the operation into the lumbar area, and also is, to some extent, unpredictable from patient to patient having operations of similar extent. It can be treated successfully by bandaging the feet and legs up to the knees and by instructing the patient to wear a snug abdominal binder for several months. It then disappears spontaneously, at least in its more marked aspects, although palpation, tachycardia, and dyspnea to some degree, (particularly on marked exertion) may persist for many months or even years. Other sequellae should be mentioned, namely, excessive perspiration of the undenervated upper portion of the body in very hot weather, and coldness in this area in winter.

Loss of ejaculation is almost invariably present if the resection includes both second lumbar ganglia. This loss occurs in about 50 per cent of cases if one 2d lumbar ganglion is preserved, and is rare if both first lumbar ganglia are removed while the second lumbar ganglia are preserved. Impotence following operations of any extent is rare. This operation is less extensive than the total or near total sympathectomy of Grimson,[16] the difference being that in the lumbodorsal procedure the head, upper extremities, heart and lungs are not denervated. In a few failures following lumbodorsal splanchnicectomy, the procedure has been extended in subsequent stages to near-total or total sympathectomy, but so far without much success.

METHOD OF STUDY

At the beginning of this investigation it seemed advisable to adopt a minimal standard outline of study for every patient. This has been continued throughout the past eight years, extended as time went on, and supplemented by more detailed study of small groups of cases as new technics have been developed and as facilities became available. The problem demands much more detailed observation of selected cases to cast further light upon underlying mechanisms.

The minimal standard outline of study is presented in detail because it forms the basis for dividing hypertensive patients into many smaller groups in which a number of variable factors are held constant. This will eventually be the basis for constructing life expectancy curves. One must have the necessary data to place hypertensive patients into groups to use the suggestions to be made about selection of cases for surgical treatment. In addition to a complete history and physical examination, the following information is deemed advisable: the occular fundi should be described in detail by an ophthalmologist, the pupils fully dilated; cardiac status should be evaluated by a cardiologist, supplemented by an electrocardiogram and a seven-foot heart plate with particular reference to the size and shape of the heart and the state of the aorta; the renal area is evaluated by urinalyses, a twelve-hour concentration test, an intravenous phenolsulphonphthalein test, the dye being injected after a period of forced fluid intake, and specimens collected at intervals of fifteen and thirty minutes and one and two hours. This ordinary test of renal function has been found to be useful in estimating the extent of renal damage in hypertensive patients and is the one we have come to rely upon most. A non-protein nitrogen determination is made and intravenous pyelograms are obtained routinely. Blood studies include counts, smears, hemoglobin determinations, blood grouping, Rh factor, Hinton, blood sugar, serum protein, cholesterol, and chlorides. If a cerebral vascular accident has occurred, neurologic consultation is requested and such additional studies as skull plates, electroencephalograms, and lumbar puncture are carried out as seem indicated.

BLOOD PRESSURE DATA

The unusual variability of blood pressure which is characteristic of most hypertensive patients and our inability to gain much insight into underlying mechanism from scattered ambulatory readings in the office or clinic taken by physicians, coupled with the early reports of Hines [17] and Brown [18] concerning the phenomenon of hyperreactivity, resulted in a decision to establish standard conditions for studying the blood pressure of each patient. Instead of trying to evaluate blood pressure on the basis of numerous readings by many indi-

viduals under varying circumstances, (as had been our previous custom) we held the conditions of study constant and established a routine which has proved helpful in dividing patients into more comparable groups as to the stage of the disorder, the severity of the hypertension, the degree of reactivity, and the type of hypertension as judged by the width of the pulse pressure. These will be commented upon in greater detail presently.

The following plan was adopted because we wished to obtain certain information in a standard fashion, which would be as dependable as possible, which would emphasize basal levels in particular, which could be utilized in studying a sizable series of patients, many coming from a distance, and which would be helpful in estimating the physiologic effects of surgical intervention. This resulted in the development of a postural and cold blood pressure test, a modification of the Hines-Brown cold test. This is performed as follows:

The patient is required to have at least forty-eight hours of bed rest except for lavatory privileges. Following this preliminary period, tests are carried out by technicians rather than physicians since the former are generally able to obtain lower readings than a physician, presumably because the doctor often acts as a pressor stimulus to the patient. Preliminary readings of blood pressure are taken on each arm. If no great discrepancy exists the right arm is used. If there is a marked difference on the two sides, this is checked a number of times and the arm with the higher readings is selected. The test is explained to the patient and after an additional rest period of fifteen to twenty minutes in the horizontal position observations are begun. The environment must be quiet, comfortable and pleasant. Ward patients are transported to a special room for the test during which there should be no interruptions. Readings of pulse and blood pressure are taken every minute for five minutes with the patient first lying, then sitting, then standing. The horizontal position is again assumed and five further readings at minute intervals are taken following which the opposite hand is immersed in ice water (4 to 5 degrees centigrade) up to the wrist for exactly one minute and readings are taken after thirty seconds and at the end of the sixty seconds of stimulation by cold. Readings are then continued at one minute intervals for an additional five minutes. The patient then assumes the upright position and after five preliminary readings at one minute intervals, the cold stimulus is repeated exactly as in the horizontal position. The data are then charted, the readings in the first portion of the test are averaged and this is taken as the horizontal or resting level. The readings in the standing portion of the postural test are averaged to be contrasted with the horizontal level. The maximal level of systolic and diastolic blood pressure during the cold test is recorded both in the horizontal and vertical positions. These are called the ceiling levels. The magnitude of the reflex response to change of position is determined by subtracting the standing average from the lying. The reflex response to the cold stimulus is determined by subtracting the reading immediately prior to the application of cold from the ceiling levels, both lying and standing. The range of variability during the test is determined by subtracting the lowest reading of systolic and diastolic blood pressure during the first (horizontal) portion of the postural test from the highest levels noted in any other portion of the test. These data give information regarding the reactivity of the vascular bed and the variability of blood pressure in hypertensive patients and can be compared with similar data from normal controls. The average figures for 100 normotensive individuals, age range 12 to 56, studied in a similar fashion (without the preliminary period of two days' bed rest) are shown in Table I. It is desirable that the postural and cold test be repeated in hypertensive patients under ambulatory condi-

TABLE I

Lying	Standing	Reflex Response	Ceiling Cold Lying	Ceiling Cold Standing	Cold Response Lying	Cold Response Standing	Maximal Variation
108	112	4	125	126	16	15	29
—	—	+ —	—	—	+ —	+ —	—
68	81	13	86	94	17	12	34

tions of study, that is, when up and about and active without preliminary bed rest. The difference between the two tests is often striking and may prove to be of prognostic significance. It was our original intention to study patients after operation exactly as before, but the war and the shortage of beds has made it impossible, so that the result of operation so far has been judged by comparing ambulatory post-operative blood pressure data with that obtained prior to operation after a preliminary period of bed rest. More recently we have been able to obtain both kinds of data before and after operation. So far, only two simple stimuli of autonomic activity have been employed. Both are of a physical nature, namely, change of posture and cold. The former induces vasoconstriction by virtue of a change in internal environmental conditions, and the latter is an external stimulus of the vasoconstrictor mechanism. It is proposed to extend these observations considerably, utilizing other stimuli, those of an emotional variety in particular.

A sedative test has been performed in all cases, Following a light supper, three grains (0.2 Grams) of sodium amytal are given by mouth at 6:00, 7:00 and again at 8:00 P. M. Hourly readings of pulse and blood pressure are recorded from 7:00 P. M. to 7:00 A. M. The lowest reading of systolic and diastolic blood pressure is taken as the response. This is evaluated by comparison with the horizontal or resting blood pressure level as determined by the postural and cold test, and the diastolic response is regarded as the more significant figure. For patients with resting diastolic levels in the postural and cold test below 120 millimeters, the diastolic response to sedation should be to 90 or less, for those in the range of 120 to 129 millimeters, it should be to 100 or less, and for those with resting levels of 130 millimeters or more it should be to 110 or less in order to be regarded as satisfactory. Better responses than this not infrequently occur and are regarded as good or excellent. A lesser response also is not uncommon and is regarded as poor.

STAGES OF HYPERTENSION

1. *The Normotensive Hyperreactor.*

In 1932, Hines and Brown [17] called attention to the fact that most hypertensive patients were hyperreactors. By this they meant that if the sympathetic nervous system was stimulated at the time the blood pressure level was basal, an unusual reflex rise would follow. They emphasized the need for basal conditions of study since if the stimulus were applied when the blood pressure was elevated above the basal level, no unusual response might be detected. They subsequently carried out a study of normal individuals and found that about 15 per cent showed the same evidence of hyperreactivity as had been noted in most hypertensive patients. This suggested that this type of "normal" might be more prone to the subsequent development of hypertension. A small series of hyperreacting normals and control normals was followed for a number of years, and it was noted that a significant proportion of the former group developed continued hypertension whereas none of the control series did during the period of observation. They felt that the normotensive hyperreactor should be regarded as a potential hypertensive patient and that this might be a prehypertensive stage of hypertension. They found that a response to stimulation by cold when the patient was resting in the horizontal position, of over 20/15 millimeters of mercury should be regarded as abnormal. As previously described, we have studied our hypertensive patients in a similar fashion and have modified the Hines-Brown cold test by preceding it with a simple postural test and have followed it by repeating the cold test with the patient in the upright position. Average values for 100 normotensive patients are found in Table I. The posttural and cold test has revealed that certain individuals, both normals and hytertensives, not only may hyperreact to cold, but to posture as well. Few hypertensives fail to hyperreact to one or the other, and some hyperreact to change of posture and not to cold.

2. *Intermittent Hypertension*

It seems probable that many patients pass through a stage of intermittent hypertension before their blood pressure levels become continually elevated. These persons are similar

to the normotensive hyperreactor in that their resting levels are within the accepted normal range, but their ambulatory levels or their ceiling levels during the postural and cold test are well out of the normal range. They cannot be distinguished from patients with continued hypertension by ambulatory readings. The borderline between the two must be somewhat arbitrary. In the early stages of intermittent hypertension, blood pressure may fall to normal promptly upon resting. Later it may require many hours or days. We have considered that if the diastolic level in the horizontal position is 90 millimeters or more after forty-eight hours of bed rest, the patient has reached the stage of continued hypertension. In general, patients seem to tolerate the stage of intermittent hypertension well, and it seems probable that many who are thought to have continued hypertension on the basis of ambulatory readings and seem to thrive for many years are actually in the stage of intermittent hypertension. Occasional patients, especially males, develop marked cardiovascular damage in this stage of the disorder, and may even have so-called malignant hypertension or advanced retinitis, or marked changes in the cardiac or renal areas (even with congestive heart failure) with blood pressures which are actually within the normal range after a period of bed rest. We have had occasion to operate upon a few such patients with excellent early results. We have also operated upon a few patients in this stage of the disorder when the ambulatory readings were always high and the reflex responses extremely abnormal, as a prophylactic measure, before cardiovascular damage of consequence had occurred.

The stage of intermittent hypertension appears to be, in most instances, largely a physiologic phase of the disorder, spontaneously reversible in response to rest. Vascular damage, however, may occur. It is well to know what stage of the disorder a patient is in, not only in the interest of the natural history of hypertension but also in judging the need for and results of different forms of treatment.

3. *Continued Hypertension.*

It seems highly probable that prior to the time the stage of continued hypertension is reached, physiologic factors have been in operation for many years. Unfortunately this is not known to be, but is almost certainly a fact. Few hypertensive patients have any accurate knowledge of the duration of their continued hypertension. In many, it is a very recent or chance discovery. Others say that their blood pressure has been elevated for many years, occasionally as long as twenty years. Yet one cannot accept the history as being significant, except in the rarest instance, since there is no way of telling when the transition from intermittent to continued hypertension occurred. Consequently our knowledge of the natural history of the disorder is defective and will continue to be so until patients who are found to have elevated ambulatory readings are studied periodically, preferably once a year, under resting conditions. If ever a simple panacea is discovered, it will undoubtedly be most effective if utilized before serious cardiovascular damage has occurred. It behooves the medical profession to take a greater interest in the natural history of this important disorder, to recognize potential hypertensives in the normotensive stage, to know whether a patient has intermittent or continued hypertension, and if the latter exists, how long it has been present. An accurate knowledge of the duration of continued hypertension would undoubtedly be helpful in predicting the efficacy of treatment. The known duration of hypertension as obtained today from patients or even physicians is of little or no value. We have arbitrarily defined continued hypertension as being present when the diastolic level is 90 millimeters of mercury or more in the horizontal position after at least forty-eight hours of bed rest. The actual level taken was the average of the first five readings in the first position of the postural and cold test which has been referred to as the horizontal or resting level.

TYPES OF CONTINUED HYPERTENSION

One of the most interesting of the variations from patient to patient in the stage of continued hypertension is the remarkable difference in the width of the pulse pressure in re-

lation to the diastolic level. This has proved to be important in predicting the outcome of surgical treatment and has been used as a basis for dividing hypertensive patients into three types. The average diastolic and pulse pressure in the horizontal portion of the postural test is utilized for typing. In Type I, pulse pressure is less than one-half the diastolic pressure. In Type II, pulse pressure is equal to or up to 19 millimeters, more than one-half the diastolic pressure. In Type III, the pulse pressure is 20 millimeters or more greater than one-half the diastolic pressure. The highest incidence of better results occurred in Type I, and the lowest in Type III, while those in Type II fell in between, being closer to Type I than Type III.

It seems probable that the wider the pulse pressure the more the larger vessels are implicated in the hypertensive state. All types of hypertension may be dramatically reversible but the fact is that in Type III, the statistical chances for the better results are much smaller than in the narrower pulse pressure varieties. Age seems to be a factor, since the greatest proportion of the younger patients are in Type I, and the older patients in Type III. Duration is probably important in relation to type but this cannot be detected from the histories. Decreased elasticity of the larger vessels undoubtedly exists in most of the wider pulse pressure hypertensives sooner or later, although the reversibility in occasional cases suggests that in the earliest stages, of at least some of these patients, this pattern may be physiologic in nature.

In general, females have done better than males, type for type. Thus, the highest proportion of the better results are in the Type I females and the lowest in the Type III males. Age is also important particularly in the wider pulse pressure varieties of hypertension, and it has been found helpful to divide the cases into two groups upon this basis, those below 40, and those 40 years of age or over. Further subdivisions on the basis of decades will undoubtedly be helpful in evaluating surgical treatment when the data are sufficient to permit such a further breakdown.

All of the 439 cases which form the basis for this report had continued hypertension as defined. Demonstrable evidence of cardiovascular damage ranging from slight to very marked was detected by the pre-operative method of study previously outlined, in 97 per cent of the cases, and was absent in 3 per cent. This discussion therefore has to do with the results of the surgical treatment of continued hypertension by lumbodorsal splanchnicectomy in patients having demonstrable cardiovascular damage prior to operation.

RESULTS OF LUMBODORSAL SPLANCHNICECTOMY

1. *Unselected Cases.*

The foregoing discussion of methods of study was deemed necessary because it forms the basis for the division of the cases into smaller groups holding several variables constant in each to determine the circumstances under which the best as well as poorest results have occurred. Results have been judged primarily by the effect of operation upon blood pressure. As a check upon this, the effect of operation upon the cardiovascular changes has been tabulated as well.

Blood pressure changes have been divided into six grades and deaths have been placed in the seventh. These have been defined as follows: 1. Diastolic pressure lowered 20 millimeters or more and to below 90. 2. Diastolic pressure lowered 20 millimeters or more but not to below 90. 3. Diastolic pressure lowered less than 20 millimeters to no change at all. Pulse pressure definitely narrowed, and ceiling levels lowered. 4. Diastolic level and pulse pressure essentially unchanged but ceiling levels lowered. 5. No change in blood pressure. 6. Blood pressure higher. 7. Deaths.

Cardiovascular status judged by the study of the cerebral, retinal, cardiac and renal areas, following operation has been graded and divided into four categories. (A) Cases with favorable changes in one or all areas with no evidence of progress in any area. (B) Cases in which there is no evidence of reversal or improvement in any area but also no evidence of progression. (C) Cases in which there is evidence of improvement in one or more areas but also evidence of progress of cardiovascular disease in another or other areas. (D) Cases

with no evidence of improvement or no change in one or more areas associated with evidence of progression in one or more areas. Deaths are also placed in group D.

The changes in blood pressure graded 1, 2, and 3 have been regarded as probably significant for the most part and are called marked, moderate and slight. Together they comprise the group labeled as "improved" in tables 2, 3, and 4. There is a close correlation between this group and cases falling in group A in which a favorable change in the degree of cardiovascular damage noted one to five or more years after operation has taken place. Blood pressure changes graded 4 are minimal and in 5 there is no change at all. Together they comprise the group tabulated as "no change" and are regarded as equivocal results, although in some, arresting the progress of the hypertension (when associated with lack of progression of cardiovascular damage) may prove to be worthwhile. The other headings in tables 1, 2 and 3 are self-explanatory. The early results of operation in 439 consecutive unselected cases of continued hypertension are shown in table 2.

2. *"Selected Cases"*

The unselected cases were divided into twelve major groups according to the two sexes, two age groups, and the three types of hypertension. This places more comparable cases together for a more detailed analysis of results. Other variable factors such as the severity of the hypertension as judged by resting diastolic level, as well as the state of the brain, eyegrounds, heart, and kidneys and the response to sedation, were then taken into consideration. With regard to eyeground changes, a very simple classification has been used. Normal, occasional patients with continued hypertension may have no demonstrable changes in the eyegrounds. Grade 1: Cases with spasm only, generalized narrowing or irregular constrictions, or both, of any degree, without evidence of sclerosis, and without hemorrhage, exudate or papilledema. Grade 2: Sclerotic changes, particularly arteriovenous compression, generally associated with tortuosity and increased light reflex. Spasm might also be present, but hemorrhage, exudate and papilledema were not in evidence. Grade 3: Patients with hemorrhage or exudate but without papilledema regardless of the changes in the vessels. Grade 4: Papilledema, measurable elevation of the disk, was the principal criterion for inclusion in this group. It is generally associated with hemorrhage and exudate and changes of consequence in the retinal arteries.

Circumstances under which results of operation are most likely to be unsatisfactory.

The circumstances under which the results of operation are most likely to be unsatisfactory are arranged in two groups. A. General, those which apply to any case; B. Specific, those which apply to cases subdivided into groups according to sex, type and age. They are worded in such fashion that if the data which have been mentioned are available it should be possible to decide with reasonable (but not absolute) certainty whether a particular hypertensive patient is a satisfactory or a poor candidate for operation.

Operation (lumbodorsal splanchnicectomy) is most likely to be ineffective—

A. 1. In the presence of nitrogen retention.

2. When actual or impending congestive heart failure is associated with poor kidney

TABLE II

SURGICAL TREATMENT OF CONTINUED HYPERTENSION
Effect of Lumbodorsal Splanchnicectomy Upon
BLOOD PRESSURE

	Improved	Unchanged	Higher	Deaths
439 Unselected Cases	65.8%	12.8%	6.8%	14.6%

CARDIOVASCULAR DISEASE

Followed 1-5 or more Years	Improved	No Change	Improved & Worse	Worse
	61.7%	10.0%	9.2%	19.1%

function, intravenous phenolsulphonphthalein output less than 15 per cent in 15 minutes and 50 per cent in two hours.

3. When renal function is poor but cardiac status satisfactory, if the patient has had a cerebral vascular accident or has grade 3 or 4 eyeground changes. Possible exceptions are cases with known pyelonephritis or an unusually marked response to sedation or both.

4. When the cardiac changes are marked, actual or impending congestive heart failure, and the renal function is satisfactory (intravenous phenolsulphonphthalein output 15 per cent in 15 minutes and 50 per cent or more in two hours) in the presence of a cerebral vascular accident or grade 3 or 4 eyeground changes. Possible exceptions are patients with known pyelonephritis or a remarkable response to sedation or both. Operation may be considered if the renal function is normal and the response to sedation satisfactory. The heart, however, must be well compensated and must have responded well to medical measures.

B. If the preceding circumstances do not apply to a particular case, the following criteria should also be considered before advising surgical treatment:

1. Type I Males—If the resting diastolic level is less than 120, operation may be performed if the general suggestions do not apply. For diastolic levels 120 to 139, age 38 or more, it has been noted that patients who have had a cerebral vascular accident or have grade 3 or 4 eyeground changes have done poorly unless response to sedation is satisfactory and the electrocardiogram or the renal function is normal (intravenous phenolsulphonphthalein output 25 per cent in 15 minutes and 50 per cent or more in two hours). If either the electrocardiogram or the kidney function is abnormal the changes should be slight at most. When the resting diastolic level is 140 millimeters or more, the outlook is poor in general. Operation in these cases seems inadvisable if there has been a cerebral vascular accident, encephalopathy, congestive heart failure, or more than slight impairment of renal function (intravenous phenolsulphonphthalein output 20 per cent in 15 minutes and 50 per cent or more in two hours). If the patient has grade 2, 3 or 4 eyeground changes, the electrocardiogram should be normal. If the eyegrounds are normal or grade 1, operation may be performed if the cardiac and renal changes are slight at most.

2. Type I Females—If resting diastolic level is below 120, operation may be performed if the general suggestions do not apply. If the resting diastolic level is 120 or more, and the patient has had a cerebral accident, or encephalopathy, or has grade 3 or 4 eyeground changes, operation may be performed if the cardiac and renal functions and the response to sedation are satisfactory. If the response to sedation is poor, and the patient is under 38 years of age, the result may be worthwhile if the elctrocardiogram is normal or chronic pyelonephritis is known to exist.

3. Type II Males—Patients under 40 years of age, to whom the general suggestions do not apply, have done poorly when the resting diastolic level is below 110 millimeters and grade 3 eyeground changes are present. Also male patients in this same age group with resting diastolic levels of 130 millimeters or more have done badly unless the changes in all areas are minimal at most. Male patients, Type 2, age 40 and over have done poorly at all diastolic levels if the response to sedation is poor. Also, if the response to sedation is satisfactory, and the resting diastolic level is 120 millimeters or more, results have been poor when renal function has been poor (intravenous phenolsulphonphthalein output of less than 15 per cent in 15 minutes and 50 per cent in two hours). If the response to sedation is satisfactory and the resting diastolic level is 120 millimeters or more and the eyegrounds are grade 3, the results have been poor unless the renal function is good (intravenous phenolsulphonphthalein output 20 per cent in 15 minutes and 50 per cent or more in two hours).

4. Type II Females—Below the age of 40, these patients have done unusually well when the general suggestions do not apply. Patients age 40 and over, to whom the general suggestions do not apply, have not done well if there has been a cerebral accident and the eyegrounds are grade 3 or 4. Also Type II females, age 45 and over have in the great ma-

jority of instances done poorly if the response to sedation is unsatisfactory.

5. Type III Males—Below the age of 40, operation may be performed if the general rules do not apply except in patients with eyeground changes greater than normal or 1, unless the renal function is normal (intravenous phenolsulphonphthalein output 25 per cent in 15 minutes and 50 per cent or more in two hours). Patients age 40 and over have done poorly if the response to sedation is poor. Patients age 45 and over with grade 2 eyeground changes have done poorly. Patients age 45 and over with grade 3 eyegrounds, and abnormal electrocardiograms have done poorly when the renal changes are more than slight (intravenous phenolsulphonphthalein output less than 20 per cent in 15 minutes and 50 percent in two hours).

6. Type III Females—Below the age of 40, these patients have done unusually well if the general suggestions do not apply. If the age is 40 or more, patients who have had a cerebral accident have done poorly unless the eyegrounds are normal or grade 1 and the diastolic response to sedation is to below 80. Patients age 40 and over with resting diastolic levels of 130 millimeters or more have done poorly.

If these suggestions are applied to the 439 unselected cases, a total of 120 patients (27 per cent) would be affected. If these are subtracted from the original group, there would remain 319 patients, who might be regarded as "selected cases". Presumably if these suggestions had been available at the beginning of this study, and followed closely, the results would have more nearly approximated those in the so-called "selected group". These are summarized in Table III. Examples of results in cases not excluded by the suggestions are shown in figures 1 to 5.

"Excluded Cases"

The results in the 120 cases to whom the suggestions apply are shown in Table IV. These are designated "excluded cases". A survey of Tables II, III and IV indicates that the results in Table III, the so-called selected group, are considerably better than in Table II, the unselected group. The difference, as is apparent from a study of Table IV, is due largely to the exclusion of the deaths and the poorest results. It is true that an occasional excluded case has so far done well. It is regretable that as yet it has been impossible to differentiate these from the other similar cases that for the most part have done poorly. Every effort will be made to find a solution for this problem. At the moment, however, it seems to the best interest of hypertensive patients in general not to recommend surgery when it is very likely to fail. The vast majority of the

TABLE III

SURGICAL TREATMENT OF CONTINUED HYPERTENSION
Effect of Lumbodorsal Splanchnicectomy Upon
BLOOD PRESSURE

	Improved	Unchanged	Higher	Deaths
319 "Selected" Cases Followed 1-5 or more Years	84.8%	11.6%	2.4%	1.2%
	CARDIOVASCULAR DISEASE			
	Improved	No Change	Improved & Worse	Worse
	76.2%	11.3%	8.5%	4.0%

TABLE IV

SURGICAL TREATMENT OF CONTINUED HYPERTENSION
Effect of Lumbodorsal Splanchnicectomy Upon
BLOOD PRESSURE

	Improved	Unchanged	Higher	Deaths
120 "Excluded" Cases Followed 1-5 or more Years	15.8%	15.8%	16.7%	51.7%
	CARDIOVASCULAR DISEASE			
	Improved	No Change	Improved & Worse	Worse
	23.3%	6.7%	10.8%	59.2%

deaths, 60 of 64, are excluded by the suggestions. Most of these occurred within a year or two of operation. Because the outlook for excluded patients is very poor, the 15 per cent to 20 per cent chance for a possibly worthwhile result almost invariably seems worthwhile to the patient and to most physicians. It is consequently difficult at times to avoid surgery in some of these patients. In general, however, we feel that it is wiser to advise against operation in the great majority of patients to whom these suggestions apply. Surgery should not be employed as a last resort.

SUMMARY

1. Bilateral lumbodorsal splanchnicectomy has been performed upon 439 unselected patients for the relief of continued hypertension.

2. Demonstrable evidence of cardiovascular damage was present in 97 per cent of the cases.

3. These patients have been followed for from one to five or more years.

4. The majority were improved, as judged both by a favorable effect upon blood pressure levels as well as by a lessening in the severity of the cardiovascular damage.

5. All of the available preoperative data have been reviewed and certain suggestions are made regarding the selection of cases for surgical treatment.

6. It is felt that if these suggestions are followed closely, that the great majority of so-called "selected cases" should benefit by this form of treatment.

7. The improved results in the "selected group" are due largely to the exclusion of the great majority of the cases who have died soon after operation or who are living and not improved.

8. Among the excluded cases are a few that have done well. Every attempt should be made to find a way of differentiating these from other similar cases which have almost invariably done poorly.

9. Among the included cases are some that have done poorly. Further attempts should be made to find the explanation for this and a way to exclude these cases from operation.

FIGURE 1. A 42-year-old male with severe type 1 hypertension. The eyegrounds showed minimal changes, grade 1. The cardiac status was normal and there was slight reduction of kidney function. Response to sedation 130/100.

BLOOD PRESSURE DATA

			Ceiling Cold		Cold Response	
	Lying	Standing	Lying	Standing	Lying	Standing
Preoperative	186	210	248	232	62	52
	—	—	—	—	+ —	+ —
	132	159	180	164	50	16
Postoperative (24 months)	92	108	120	128	20	28
	—	—	—	—	+ —	+ —
	70	89	80	90	12	12

This is a so-called grade 1 result. Two years after operation the patient is well, very active, asymptomatic. The eyegrounds and kidney function are normal.

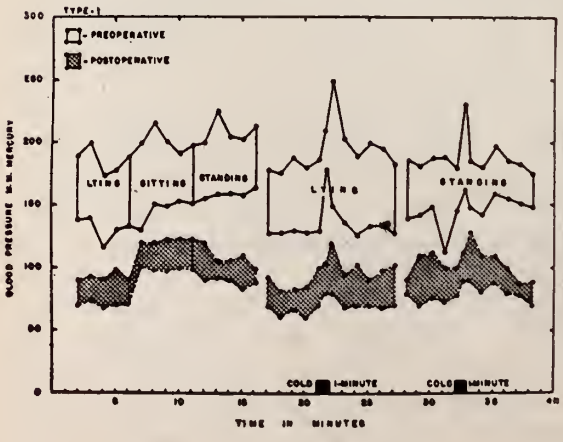


FIGURE 1

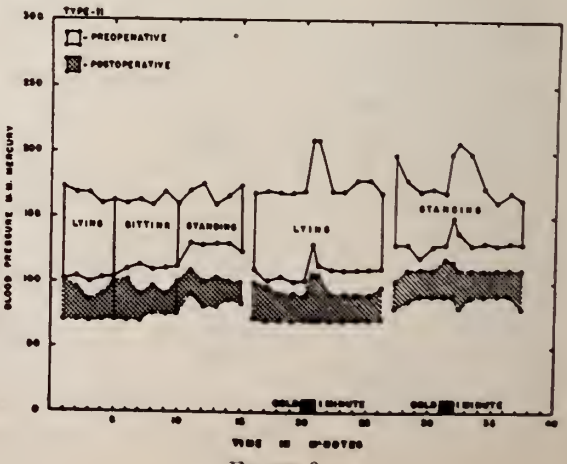


FIGURE 2

10. In general it seems inadvisable to recommend operation under circumstances when chances for improvement are slight and chances for failure great. It would seem wiser to advocate surgery before the disorder is too advanced rather than as a last resort.

11. The effect of removing the vasoconstrictor nerves to a large portion of the visceral vascular bed suggests that the sympathetic nervous system plays an active and important role in the development and natural course of the majority of cases of hypertension and hypertensive cardiovascular disease in man.

FIGURE 2. This 32-year-old female patient had malignant hypertension, type 2. Known duration of elevated pressure was 3 years. The eyegrounds showed marked changes, graded 4, with hemorrhage, exudate, papilledema, and severe arterial abnormalities. The cardiac area varied little from the normal, there being a slight change in the shape of the heart. The electrocardiogram was normal. The aorta was tortuous. There was persistent albuminuria, and slight decrease in renal function. Response to sedation 120/90.

BLOOD PRESSURE DATA

			Ceiling Cold		Cold Response	
	Lying	Standing	Lying	Standing	Lying	Standing
Preoperative	167	170	210	208	40	38
	—	—	—	—	+ —	+ —
	102	130	158	150	26	20
Postoperative	94	102	105	110	15	8
(32 months)	—	—	—	—	+ —	— —
	70	85	70	80	0	10

This is a so-called grade 1 result. The patient feels very well, is active, the eyegrounds show slight spasm only, the albuminuria has disappeared, and the renal function is improved and is well within normal limits 32 months after operation.

FIGURE 3. A 42-year-old female with a wide pulse pressure variety of hypertension, type 3. Eyegrounds grade 3, heart moderately enlarged with impending congestive failure, definite electrocardiographic changes (figure 4) and moderate reduction in kidney function with persistent albuminuria. Chronic inactive pyelonephritis was also present.

BLOOD PRESSURE DATA

			Ceiling Cold		Cold Response	
	Lying	Standing	Lying	Standing	Lying	Standing
Preoperative	227	230	284	250	44	50
	—	—	—	—	+ —	+ —
	123	133	158	144	34	14
Postoperative	143	156	180	158	18	24
(36 months)	—	—	—	—	+ —	+ —
	90	110	96	120	10	18

Three years after operation the patient is greatly improved. Eyegrounds grade 1. The signs of failure had disappeared, the heart was smaller in size, and the electrocardiogram improved, and the renal function was normal. A so-called grade 2 result.

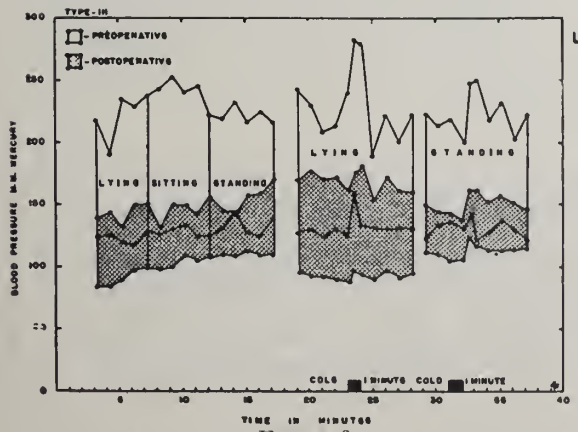


FIGURE 3

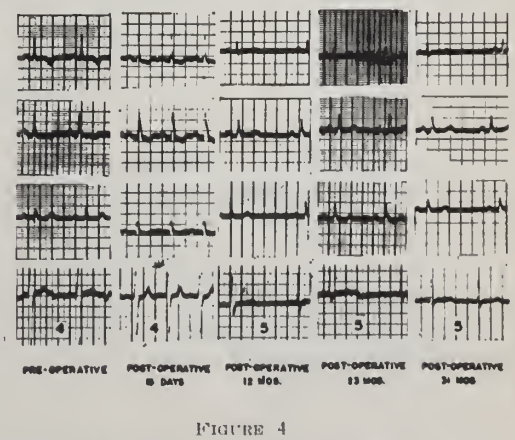


FIGURE 4

FIGURE 4. The same patient as in figure 3. The electrocardiogram shows a definite and persistent improvement. This matter has been discussed in a number of communications by P. D. White and his associates.(19,20,21,22)

FIGURE 5. A 31-year-old male with type 3 hypertension, grade 3 eyes, an enlarged heart and abnormal electrocardiogram, normal kidney function, response to sedation 140/100. One year after operation he was generally much improved. The eyegrounds were grade 1, the electrocardiogram was greatly improved, the kidney function remained normal.

BLOOD PRESSURE DATA

			Ceiling Cold		Cold Response	
	Lying	Standing	Lying	Standing	Lying	Standing
Preoperative	226	250	290	296	76	38
	—	—	—	—	+ —	+ —
	110	122	240	130	16	12
Postoperative (1 year)	146	147	180	184	22	36
	—	—	—	—	+ —	+ —
	103	109	118	130	12	24

This is a so-called grade 3 result. The change in diastolic pressure is slight. There is however a marked narrowing of pulse pressure and the ceiling levels are much lower. Results of this sort appear to be worthwhile and are associated in most instances with reversal in the degree of vascular damage as in this case. Together with grade 1 and 2 results, (figures 1, 2 and 3) these comprise the cases recorded as improved so far as blood pressure is concerned in tables 2, 3 and 4.

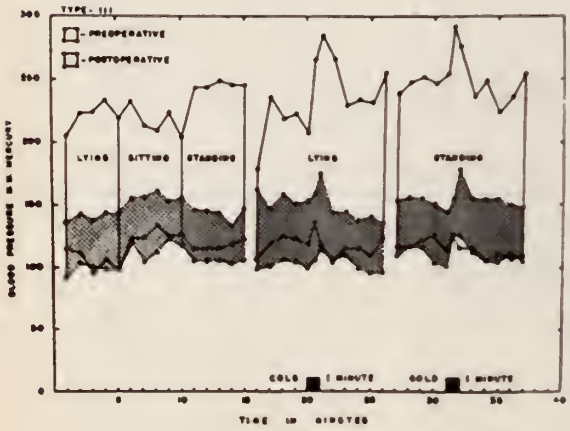


FIGURE 5

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750 Harrison Avenue

MEMORANDUM FOR DOCTORS WHO USE X-RAY OR RADIUM

Since the use of x-ray and radium is considered an extra insurance hazard, the malpractice carrier will not assume responsibility for suits for personal injury resulting from the use of these modalities unless this item is specifically included in the malpractice policy. If you use any radium or x-ray, check your policy to be sure that this is covered; and if it is not, make application immediately for additional coverage.

THE BACKGROUND OF THE ANTI-HISTAMINE SUBSTANCES

Charles F. Post, M.D.,* New York City

Histamine was first prepared synthetically by Windaus and Vogt in 1907.[1] At this time histamine was known by its chemical name, beta-iminazolylethylamine, and for brevity was called beta-I.

Beta-I is produced when carbon dioxide is split off the amino acid histidine. This is represented in figure 1.

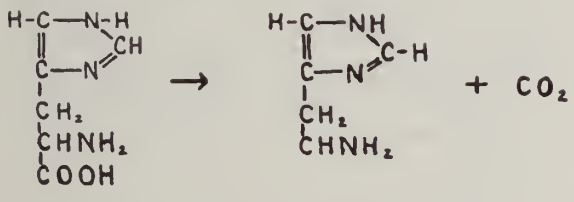


Figure 1. Structural Formulae.

In 1910 Ackermann [2] obtained histamine by submitting histidine to the action of putrefactive organisms of the intestine. This was the first indication that histamine may be a constituent of the body. In June 1910 Barger and Dale [3] reported that they had isolated beta-I from ergot. At about the same time Ewins and Pyman [4] prepared beta-I synthetically from histidine. With the indications that beta-I should be found in the animal organism, Dale and Laidlaw [5] in 1910, set out to extract histamine from animal tissue.

Extracts were made from intestinal mucosa. These workers obtained samples of the material isolated by all of the above experimenters, and identified their intestinal extracts as being of the same chemical composition as the samples.

The compound obtained by Dale and Laidlaw was used by them in a series of physiologic tests. The main effects were:

1. Vasodilatation.
2. Contraction of smooth muscle.
3. Secretagogue effect. (stomach)

They also discussed its action on the bladder, stomach, uterus, and respiratory system, and in every case its action was like that of the synthetic preparations of beta-I. Thus, the occurrence in the body of beta-I, or histamine, was established.

Outstanding work was produced between 1924 and 1927 by Sir Thomas Lewis.[6] His object was to compare the stroke reaction of the skin to the reactions produced by chemical and physical methods. Dale suggested the use of beta-I, now under the name of histamine, because its responses were similar to those produced by stroking the skin.

In response to stroking, chemical injury, burning and histamine puncture, the following group of reactions appear:

1. *The red reaction*—appears almost immediately after the stimulus is applied, over the line of stroke.
2. The *flush* or *flare*—Soon after the red line this appears surrounding it with an irregular edge.
3. After this, the red line, or the line of stroke, is replaced by *the wheal.*

1. *The red line*: By direct microscopic examination of the skin the reaction can be seen to be due to dilatation of the minute vessels of the skin, the terminal arterioles, the capillaries, and venules. The red line appears without the intervention of the central nervous system or a local nervous reflex. It can be seen in an area where the nerves have been cut and have degenerated.

2. *The flush or flare*: This does depend on local nervous reflexes, and is produced by dilatation of the arterioles supplying that area of the skin. That the dilatation of the muscled arterioles is the mechanism can be demonstrated in the following manner:

1. The color of the reaction has an arterial tint.
2. The flush will not appear if arterial circulation is occluded, and
3. If the venous return be occluded for several seconds before the stimulus is given, (so that the extremity is cyanotic) the flush or flare appears vividly, a bright red in contrast to the surrounding blue skin.

* Assistant Resident in Dermatology and Syphilology, The Roosevelt Hospital, New York City, and Assistant Dermatologist to the Vanderbilt Clinic, New York.

The local reflexes concerned in the flush or flare can also be shown:

(1) When a local anaesthetic is introduced at the site of the reaction, the flare is reduced.

(2) When a nerve root is injured just before the response is evoked (fresh injury), a full response is obtained.

(3) In regions of degenerated nerves, no flare can be produced either by stroking or by histamine. It was believed, therefore, that there could be local arteriolar dilatation without the intervention of the central nervous system.

3. *The Wheal*: Obviously, this is edema of the region of the stroke or insult to the skin. The mechanism is increased capillary permeability. When trypan blue is injected into the circulation of an animal, increased permeability of the capillaries can be detected by the subsequent presence of the dye in the tissues. Rocha e Silva and Dragstedt [7] made extracts of lung, liver and muscle, and these extracts were injected into the subcutaneous tissues of the rabbit. When trypan blue was introduced into an ear vein, exudates of the dye were found in the tissues at the site of the subcutaneous injection of the tissue extract. A comparison was made of the histamine content of the tissue extract, and the degree of capillary permeability. It was found in every case, that the tissue extracts that were high in histamine produced the greatest responses. It seems, therefore, that the degree of capillary permeability is influenced directly by the amount of H-substance mobilized at the site of the edema.

CHEMICAL BASIS OF THE TRIPLE RESPONSE

By means of extensive studies, Lewis demonstrated that whether an insult to the skin be chemical (acids, alkalis, etc.), electrical or physical (as in stroking the skin) the response to the insult is invariably the same, and is in all ways similar to the response obtained when histamine is introduced through a pin prick into the skin.

Lewis felt that the response was so complicated, yet so consistent, that it was logical to fix responsibility on some liberated substance. Since proof that this liberated substance is histamine is not absolute, but rather one of inference, Lewis preferred to call the liberated material H-substance.

Lewis felt, and rightly so, that his thesis would be greatly strengthened if the presence of histamine in the human skin could be demonstrated. Up to the time of publication of his monograph in 1927, this had not been accomplished.

In 1927, K. E. Harris [8] probably did succeed in extracting histamine from the human skin. Skin was obtained from operations and a crude extract was made with absolute alcohol. The extract had a whealing effect on the skin, and it was assayed by giving it intravenously to cats. In these animals a blood pressure fall was noted as is found when histamine is given in a similar manner.

HISTAMINE CONTENT OF THE BLOOD

In 1937, C. F. Code [9] reported a chemical method for the quantitative determination of histamine.

In 1940, using Code's method of analysis, Rose [10] reported that the normal blood content of histamine is 4 gamma per 100 cubic centimeters. He was able to detect some rise in blood histamine in certain allergic individuals when urticarial phenomena were produced.

Code [11] once again, in 1944 showed that in guinea pig anaphylaxis the blood histamine may rise to three to nine times normal. Since his animals died of asphyxia, he controlled his experiments by killing his pigs with nitrogen asphyxia. In the latter instance there was no increase in the blood histamine.

In 1941 Katz and Cohen [12] reported on the histamine content of the blood of allergic and non-allergic individuals when the blood was incubated with allergens. Venous blood from the non-allergic person was incubated with an allergen, (giant ragweed, house dust, etc.) at 37° for fifteen minutes. No rise in the histamine content of the blood was found. On the other hand, when the blood of an allergic person was incubated with the respective allergen, a considerable rise in the histamine content of the plasma was detected.

Finally, in 1942, Katz [13] produced something of a clincher on the subject. He used allergic patients as his subjects. Cantharides plaster

was used to denude a small area of skin. Now, by inverting a funnel over the skin, and perfusing the system with saline all the exudate was collected. A control period was run, and then the exudate was collected after the injection of ragweed extract at the site. The amount of histamine base released per square centimeter of skin was more than doubled in thirty minutes after the injection of the ragweed extract.

In summary, C. A. Dragstedt [14] states, "The release of histamine is at least a major factor in the production of allergic symptoms in man although it is not necessarily the only factor involved. Whereas histamine has been isolated from many tissues and identified as such it has not been caught red-handed at the scene of the crime." And Rackemann [15] in his 1946 annual review of allergy said, "On the whole the histamine theory is plausible. The injection of it into normal animals or human beings can mimic all the symptoms of allergy and anaphylaxis. It offers a reasonable explanation of the fact that a uniform symptom complex can be produced by a variety of exciting causes."

ANTI-HISTAMINE THERAPY

The attempts at anti-histamine therapy have followed three main channels.

1. Histaminase, the specific inactivating enzyme for histamine has been tried, and found too toxic for therapeutic use.

2. Attempts have been made to desensitize the tissues to histamine itself. Histamine given slowly intravenously is apparently of considerable value in the treatment of the "Horton headache". This type of treatment has not been found useful in other allergic phenomena. Histamine has been combined with other proteins, such as globin, or amino acids, and these products have been used for desensitization. Such a product is sold under the name of "Hapamine".* This is being used to some extent.

3. We have the thesis of competition at the cell receptor, as propounded by Rocha e Silva.[16] The imidazole portion of the histamine molecule is proposed as the portion of the molecule which attaches itself to the cell receptors of the tissue. The remainder of the molecule is presumed to be the active portion in the allergic phenomena. This concept is like that advanced for the action of the sulfonamides, wherein the drug replaces necessary metabolites which attach themselves to the surface of the bacterial organism and are necessary for the life of the organism. See figure 2.

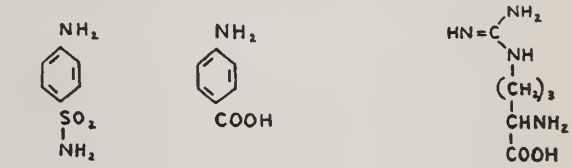


FIGURE 2. Arginine and the Sulfonamides.

It has been found, then, that histidine (imidazole group) and arginine will diminish the action of histamine when tested on an isolated strip of guinea pig intestine, presumably by competing with histamine in the cell receptor mechanism.

Recently the antihistamine drugs have made their appearance. The two in common use are benadryl ‡ and pyribenzamine.† See figures 3

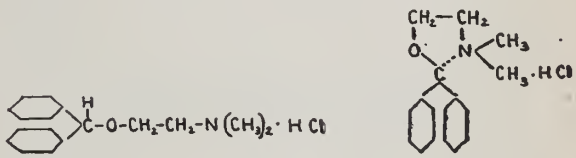


FIGURE 3

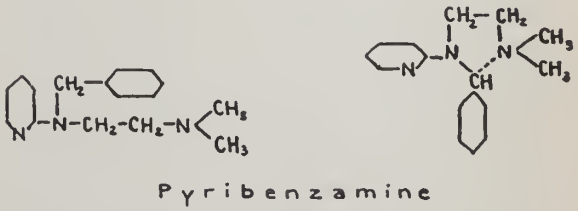


FIGURE 4

and 4. The justification for calling them antihistamine drugs appears to be adequate, and samples of the evidence can be shown as follows:

* Parke, Davis Co., Detroit, Michigan.
‡ Parke, Davis Co., Detroit, Michigan.
† Ciba Pharmaceutical Products, Inc., Summit, N. J.

1. During the administration of the drugs to normal individuals the amount of free and combined hydrochloric acid in the stomach diminishes. Moreover, there is little or no gastric acidity response to the administration of histamine.

2. McGavack et al[17] have shown that by applying benadryl as an ointment to the skin, or by oral administration of the drug, the skin response to a puncture through a drop of histamine is diminished or absent.

The evidence seems to point to the fact that the mechanism of action of benadryl and pyribenzamine is competition at the cell receptor mechanism. By bending the side chain of the compounds, and with a little imagination, it can be postulated that the similarity of these compounds to histamine is sufficient to deceive effector cells into accepting pyribenzamine or benadryl instead of histamine and thereby allaying the damaging allergic reactions.

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NOTE: Since the article was submitted, a brilliant summary of the histamine problem (with emphasis on treatment) has appeared. This is S. M. Feinberg's *Status of Histamine and Antihistamine Agents,* in the Journal of the American Medical Association, 132:702, November 23, 1946—C.F.P.

Roosevelt Hospital
New York City

THE PHYSICIANS' POST

Post 445, American Legion is the only veterans' organization in New Jersey limited to physicians. It is called The Physicians' Post. Doctors who enroll prior to September 27, 1947, will be considered charter members. Membership is open to any person, now a physician, regardless of race, color or creed, who had active and honorable service in the Army, Navy or Public Health Service during either war. Communications should be addressed to Membership Committee, Physicians' Post, Box 864, Newark 1, New Jersey. The post will be formally instituted on September 27, 1947; and will meet regularly thereafter on the third Wednesday evening of each month at the Academy of Medicine in Newark.

ANNUAL REPORT WIDOWS AND ORPHANS SOCIETY

The Society for the Relief of Widows and Orphans of Medical Men, New Jersey's unique mutual benefit medical organization announces current assets of $71,650.50. In all, the society enjoyed receipts of $12,511.60 last year. Of this, $7,760 represented income from assessments and initiation fees. During the year, the society paid to heirs of medical men, an aggregate of $4,698.50. Operating expenses of the society were only $530.83 for the entire year. During the period from May 1, 1946, to May 1, 1947, ten members died, and thirteen new physicians were admitted to membership. As of May 1, 1947, there were 543 members on the rolls. Dr. Charles H. Schlichter is president of the society. Inquiries and applications should be directed to the secretary, Dr. William D. Miningham, 18 Hedden Terrace, Newark 8, New Jersey.

SOME OBSERVATIONS ON SUBACUTE BACTERIAL ENDOCARDITIS

Estelle E. Kleiber, M.D., New Brunswick, N. J.

Previous to the era of antibiotics, the diagnosis of subacute bacterial endocarditis was of academic interest to the clinician but of little aid to the patient. It was a disease in which spontaneous recovery was a medical miracle. Today the prompt and early recognition of the disease, together with vigorous and persistent treatment may mean the difference between life and death to the patient. It is therefore fitting to reconsider this disease and to stress certain points in treatment through illustrative cases.

CASE 1

A 21-year-old male truckdriver was first referred to me on March 12, 1945, three weeks after onset of illness. Presenting symptoms were recurrent bouts of chills, fever and abdominal pain. A slight sore throat had preceded these complaints. He had had no previous rheumatic or known cardiac history. Heart examination showed a frank aortic insufficiency and cardiac enlargement. After two positive blood cultures for streptococcus viridans had been obtained, treatment with penicillin was initiated on March 17, 1945, which was 26 days after estimated onset. A total of 5,250,000 units was given intramuscularly. Except for a splenic infarct the patient ran a relatively uneventful course with prompt remission and normal temperature throughout. Because of extensive dental caries and infection it was felt best to do necessary extractions and dental work while the patient was in the hospital under penicillin. As an added precaution sulfadiazine by mouth was given during this period. Blood cultures after cessation of treatment remained negative, and when last seen on July 20, 1946, he was free from symptoms and working.

This case illustrates the favorable outcome of prompt treatment before embolic phenomena prevent complete recovery. No penicillin or sulfonamides had been used before diagnosis. The dental sepsis may have been the source of the organism in this case.

CASE 2

A 22-year-old male was admitted to Saint Peter's Hospital on February 14, 1945, with a temperature of 103.8 degrees and right hemiplegia. He had been ill only a few days and had his embolic cerebral accident on the morning of admission. There was a history of "rheumatism" at five years and a note of dyspnea on exertion on his previous admission two years previously for gastric ulcer. Examination on admission disclosed rheumatic valvular disease both mitral and aortic. Blood culture one day after admission was positive for streptococcus viridans. Penicillin and sulfadiazine were initiated on February 16, 1945, five days after onset of symptoms, and 6,000,000 units of penicillin were administered intramuscularly. After the first week the temperature remained at normal levels, though the motor aphasia and hemiplegia persisted. When last seen on September 10, 1946, he was free of cardiac symptoms though the speech defect and paralysis of the hand have prevented gainful occupation.

One doubts the short duration noted in this history in view of the height of fever demonstrated on admission, so that it is difficult to estimate the true course of the disease in this patient.

CASE 3

A 25-year-old housewife was admitted to the hospital on September 11, 1945, because of fever (104 degrees). She had had a normal delivery three and a half months previous to onset of symptoms. There was a history of rheumatic fever at the age of eight and in two previous pregnancies a note had been made of an apical systolic heart murmur. She had been treated in another city for one week but it is not known what drugs were used. When admitted to Middlesex General Hospital she had albumin, casts, red blood cells and leucocytes in her urine. A tentative diagnosis of pyelonephritis was made. Penicillin was given for five days and was then discontinued because the temperature was normal. There was three further flare-ups each controlled by penicillin and recurring within a few days after discontinuing the drug. Blood cultures were taken on September 12, and on September 24, but as both these were during the administration of penicillin, it is not surprising that they remained sterile. Two weeks after admission, I first saw the patient and made a tentative diagnosis of subacute bacterial endocarditis, advising the continued administration of the drug for at least four weeks. For some reason it was again discontinued four days later and when the temperature again rose, a positive blood culture was secured for streptococcus viridans. Larger amounts of penicillin were then given, 150,000 units in each three hour dose. During the treatment the patient developed signs of aortic valve disease with the accompanying peripheral vascular signs. She did well for a few weeks and temperature remained normal. However she developed a cough and dyspnea with signs of cardiac insufficiency for which she was digitalized. The failure was progressive, tachycardia became pronounced and she died in left ventricular failure. Total dosage of penicillin was 12,655,000 units.

The precipitating factor in this case may have been the delivery which provided occasion for a transient bacteremia from the placental site. The onset was explosive and the course characterized by progressive involvement of the valves. It was remarkably free

from embolic episodes except possibly in the kidney, the urinary findings being consistent with renal involvement.

Total dosage of penicillin was far larger than in the previous cases and given over a period of six weeks but with a dangerous intermission of treatment. When first used, the nature of the illness was not clear so that on an empirical basis penicillin was discontinued when fever was controlled. Death apparently resulted not from the septicemia but from the mechanical failure induced by growing vegetations and the myocardial strain of a long standing infection.

CASE 4

A housewife, age 46, had been treated by me since 1944 for rheumatic mitral disease with cardiac enlargement. She had already known of heart disease for sixteen years and had been taking digitalis for an undetermined number of years. There was no definite history of rheumatic disease in childhood.

Onset was insidious, and as far as can be determined the illness began early in March 1946, when the patient noted a fast heart beat. On March 14, 1946, she visited the office. At this time the only new finding was an auricular fibrillation at a rate of approximately 100. In spite of increase in the dose of digitalis, this rate was not reduced and four days later she developed a severe pulmonary embolus and a low grade fever. Blood cultures five days later first showed growth of streptococcus viridans. A renal embolus and one to the right foot followed within a few days of the pulmonary distress, with an abdominal embolus (possibly mesenteric) ten days later. Penicillin was first given on March 26 (twenty-six days after symptoms were first noted). A total of 6,380,000 units were injected intramuscularly up to April 24, 1946. Two blood cultures thereafter remained negative and there was no temperature rise after the first few days nor after her discharge from the hospital. Her heart rate is now a controlled fibrillation at approximately 70. Her general condition is not as good as previous to her present illness. She has failed to regain her former weight because of persistent indigestion and intolerance for fatty foods. She will need further observation and cultures before one can be sure of the outcome.

An interesting aspect of this case is the appearance of auricular fibrillation as the initial symptom. Many cardiologists believe that bacterial endocarditis practically never develops in the presence of this arrhythmia. In 1927 Rothschild, Sacks and Libman[1] reported four cases of auricular fibrillation in 123 patients with subacute bacterial endocarditis and in only one of these cases did the arrhythmia develop during the active stage of the disease. A recent review of this subject by McDonald[2] suggests that "the coexistence of auricular fibrillation and bacterial endocarditis is not so rare as previously supposed and one should, therefore, be cautious in using this point as a diagnostic aid."

Other features of this case were the absence of any noticeable fever until the rapid succession of severe embolic phenomena to the viscera and the absence of any evident precipitating factor.

CASE 5

A 29-year-old housewife was referred to me on June 17, 1946, for diagnosis and treatment. She had been told of a heart murmur in 1936, but had never had rheumatic or cardiac symptoms. In December 1945 she had been delivered of a normal child. One month later she had run a low grade fever, complained of paln in fingertips and was treated with liver and iron, plus penicillin for ten days only. Symptoms recurred frequently in the intervening months and she returned to bed at intervals. Four days before I first saw her she had acute left upper abdominal pain with nausea and vomiting. Temperature was 101 degrees; she was pale, had a rapid regular pulse, signs of a frank aortic insufficiency, tenderness and enlargement of the spleen and clubbing of the fingers which was recent. As penicillin had again been started a few days before (five months after onset) it was felt inadvisable to interrupt her drug to obtain a blood culture. A blood culture taken June 15, 1946, while still taking the drug was negative. Five days after the splenic infarct she had a cerebral embolus with aphasia and right hemiplegia. Penicillin was continued intramuscularly for five and a half weeks with a total dosage of 8,400,000 units. Temperature remained normal except for a few days at the onset of the cerebral accident.

A blood culture taken ten days after discontinuing the drug remained negative for three weeks after which time streptococcus viridans appeared in the broth. The laboratory reported this organism as highly sensitive to penicillin in vitro. At this time (August 17, 1946) the patient was symptomless and ambulatory but within a few days, developed an Osler's node on the right index finger and later a small ecchymotic area on the right leg. She is taking penicillin at the present time. The hemiplegia is clearing gradually and temperature is normal.

As in Case 3, the delivery probably provided the opportunity for the organism to invade the bloodstream. Earlier continued treatment might have prevented the present disability which occurred late in the course of the disease. One may hope that persistent treatment and repeated cultures thereafter will accomplish clinical arrest of the disease.

CASE 6

A 41-year-old clerk was seen by me in consultation on July 11, 1946, twenty-four hours before

death. Her illness had started suddenly with arterial thrombosis of the right femoral artery on April 13, 1946. This was treated with gradual recovery. During her hospitalization for this condition there was only an occasional low grade temperature (below 101 degrees) and an increasing anemia with rising leucocyte count. She recalled a mild "neuritis" in childhood but had never had cardiac symptoms at any time. Three days before I saw her she had suffered a severe pulmonary embolus attended by dyspnea, cough, tachycardia and cyanosis in spite of oxygen. She had clubbed fingers which she declared were recent in origin, a friction rub, and a palpable spleen. No murmurs were elicited but the tachycardia and "chest noises" may well have obscured them. An immediate blood culture was ordered and within twenty-four hours was reported showing innumerable colonies of streptococcus viridans. No penicillin had been given in this case.

This patient had surprisingly few complaints aside from her two embolic episodes. She died of an overwhelming septicemia plus the results of a severe pulmonary embolus. In view of the type of organism, history of murmur and otherwise unexplained emboli in a person with normal blood pressure and regular rhythm, one may presume the probable focus to have been on the heart valve.

FEVER AND CHEMOTHERAPY

While high fever may be the first sign of illness, in a number of cases the fever is unimpressive and in an ambulatory case (or one confined at home) it may be overlooked. The finding of fever may be unfortunate to the patient since it may point to infection without pointing to a diagnosis. There is a tendency for all of us to use sulfonamides and penicillin for relief. Since these drugs will frequently relieve the fever and even the other symptoms when used in ordinary doses, the physician and patient are lulled into a false sense of security and treatment is stopped far short of amounts needed for permanent arrest or cure. Even more important is the fact that we are possibly thereby enhancing the virulence of the organism and inviting penicillin-fastness which may resist later adequate treatment, or be so long delayed as to cause death from complications, such as massive emboli or heart failure.

CLUBBED FINGERS

Clubbing of the fingers is often an important clue but it is a comparatively late sign. It occurs in many other conditions and is not significant if of long duration. Women, however, (and many of these patients are women) almost invariably notice any change in the contour of the nails and if questioned regarding them will accurately describe the characteristic alteration in shape.

ONSET

While the onset of the disease is insidious, the patient may not be aware of any serious ailment until the sudden dramatic appearance of an embolic complication to one of the viscera or to the extremities. This may center the attention of the physician on a localized area of the body, e.g.:—leg, abdomen, kidney, lung, brain, until multiple embolic episodes reveal the true nature of the disease and point to the heart as focus. Pulmonary embolus too may be confused with acute left ventricular failure.

ANEMIA AND PETECHIAE

Progressive anemia accompanied by a rising leucocyte count, needs further investigation especially if in a young person and if not responding to ordinary treatment.

Petechiae, splinter hemorrhages, and frank nosebleeds, may not be noted early enough to help in diagnosis. None in this series presented such findings. According to White[3]: "They are evidently the result of damage to the vessel walls by a toxin which allows leakage of blood whenever pressure, trauma or some other factor favors it. The petechiae are therefore related to the hemorrhagic tendency of which a common sign is nosebleed, rather than to embolism". Control of the infection by treatment would, in itself, combat the anemia and prevent formation of these toxins.

CONCLUSIONS

1. The practitioner should develop a high degree of suspicion as to the possibility of this disease in any patient who (a) has a heart murmur (b) or a rheumatic history, or (c) an obscure low grade fever, or (d) who has developed emboli to the brain, lung, leg or other areas without adequate explanation, or (e) who suddenly develops heart failure after being fully compensated for years and whose

heart failure is not explicable by one of the usual precipitating factors like exertion or intercurrent infection, or (f) who develops a febrile illness or persistent anemia following delivery especially if even a slight heart murmur had been noted.

2. The practitioner should not give penicillin or sulfonamides to a cardiac (or to a potential cardiac) until adequate and convincing evidence of the cause of the infection has been presented or until a blood culture (or repeated blood cultures) have ruled out the possibility of sub-acute bacterial endocarditis.

3. Once treatment has been initiated it must be continued for the usually accepted period of time even though the patient has no fever or reports a sense of well-being. Treatment must not be interrupted or carried on irregularly during this period.

4. Early diagnosis of subacute bacterial endocarditis should assure the patient of a reasonable chance of survival. Early treatment should aim not only at survival but also at the return of the patient to his previous clinical state, and should be directed at the avoidance of such irreversible sequelae as hemiplegia, speech defects, amputations, cardiac failure or kidney damage.

For a review of penicillin dosage and treatment procedures, the reader is referred to Hunter's excellent monograph[4].

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131 Livingston Avenue

STREPTOMYCIN FOUND EFFECTIVE IN INFLUENZAL MENINGITIS

A highly fatal disease—influenzal meningitis—is yielding to the therapeutic power of streptomycin.

Four investigators, writing in *The Journal of The American Medical Association,* state that complete recovery is possible when this new antibiotic drug is used in cases of average severity.

A total of 25 patients were studied at Columbia University by Alexander and Leidy, and at the Squibb Institute by Rake and Donovick.

Influenzal meningitis, which is caused by a bacillus, should not be confused with true influenza, which is a virus infection.

Twelve patients whose infections were moderately severe recovered promptly and completely after treatment with streptomycin. The duration of infection prior to streptomycin treatment was less than eight days in all cases.

The other 13 patients, the majority of whom had the severe form of the infection, received rabbit antiserum, sulfadiazine and streptomycin. Three of the patients with the severe chronic form of the disease died.

The investigators point out that "in the severe infections the results suggest that therapeutic failure will be reduced to a minimum by the initial use of all three agents, i. e., rabbit antiserum, sulfadiazine and streptomycin."

Speaking of the 22 patients who survived, the authors state that "although it is appreciated that the increase of survivals in this group may increase the incidence of mentally defective children, this therapeutic program must be given a trial until it is demonstrated that all the patients who recover from such infections show severe permanent mental deterioration."

ATYPICAL ACUTE APPENDICITIS

Jacob Riese, M.D., Jersey City, N. J.

Acute appendicitis still ranks high on the list of causes of death. Portis ranks it as fifth for all the causes of death in 1935 and as high as second in the causes of death for the early age groups. In spite of the publicity given modern mechanical and scientific methods of diagnosis, acute appendicitis remains essentially and very frequently a diagnostic problem in clinical acumen. In the last analysis there is no short cut to the diagnosis of this disease. Sound clinical judgment is the *sine qua none* upon which both physician and patient alike must depend. The classical symptoms of acute appendicitis need not be detailed here. Any third year medical student can make the diagnosis when presented with the text book picture. In the consultation practice of a gastroenteroligist most cases of acute appendicitis are seen in the atypical form, since obvious cases require the services of a surgeon as soon as the diagnosis has been made. The atypical cases so frequently vary in their onset, symptoms and physical findings that the possibility of acute appendicitis should be borne in mind whenever the physician is confronted by an obscure and puzzling diagnostic problem. Herewith are presented a number of cases taken from my files during the past year with which I wish to illustrate this point.

CASE ONE

This patient was four months pregnant and presented excruciating pain in the right flank and over the right loin. It had begun two days earlier with diffuse upper epigastric pain and vomiting. She visited her obstretrician who sent her home with the diagnosis of "gastro-intestinal upset". The vomiting continued all the following day, and the pain gradually moved to the right kidney area, with radiation to the right groin. There was increased frequency of urination. Examination did not reveal any tenderness or rigidity in the right lower quadrant. A rectal examination was negative. The white cell count was 18,000 of which 90 per cent were polymorphonuclears. Urine was negative. A film of the abdomen taken in the upright position did not disclose evidence of air under the diaphragm, nor were there any signs of intestinal obstruction, or of renal calculus. Barium enema revealed a high retro-caecal appendix pointing toward the right kidney area where maximum tenderness existed. A diagnosis of acute appendicitis was made and the patient was hospitalized. The surgeon refused to operate until after consultation with a genito-urinary surgeon. Twenty-four hours after admission to the hospital patient was operated upon with the surgeon still in doubt as to the diagnosis. The appendix was found to be inflamed and gangrenous.

In this case only a careful interpretation of clinical and laboratory findings led to the proper diagnosis.

CASE TWO

A woman presented a three-day history of epigastric pain, nausea and vomiting. When seen by me, the patient had tenderness in the right lower quadrant without rigidity. Temperature varied between normal and 99°, white blood cells numbered 9000 with 80 per cent polymorphonuclears. She was fairly comfortable and eating regularly and well. At operation, the surgeon found a ruptured appendix which had begun to localize. Patient made an uneventful recovery.

CASE THREE

This patient had been ill for five days with pain and cramps in the lower abdomen. She had attended a dance the evening before she was seen by me, but had to leave early because of nausea. When seen, she was lying comfortably in bed, had a temperature of 99½. There was tenderness over the right lower quadrant but no rigidity. Rectal examination disclosed tenderness of the caecal area. Blood count was 15,000 white cells; of them 88 per cent were polymorphonuclears. Operation the same day disclosed a perforated appendix with abscess formation which had become localized.

The appendix was removed. Patient made an uneventful recovery and the temperature was down to normal in 48 hours.

CASE FOUR

This patient was the mother of case three. After the appendectomy on her daughter, the mother developed severe pain in right lower quadrant, requiring narcotics and sedation. There was no fever; blood count and urine were normal. A complete x-ray examination of the gastro-intestinal tract was made and an intravenous pyelogram done; all of this was negative. The right lower quadrant pain continued to recur. After observation for one month, and at the patient's insistence, operation was performed and the appendix removed. The appendix was six inches in length, and not diseased.

In these three cases, all the patients were well-known to each other. While the findings are not unusual, it is well to note the difference between each of them. Patient number four has had no recurrence of her abdominal pains since the operation, and it is difficult to explain her symptoms except on the basis of a neurosis.

CASE FIVE

This 41-year-old man was suddenly stricken with weakness and cold sweat, followed by epigastric pain, sharp enough to "double him up". The pain was cramp-like in character and continued to come and go during the day and remained generalized over the abdomen. No tenderness was noted and no rigidity was present. Blood pressure was 120 over 80. Temperature was normal. The physician who first saw him thought the patient had a coronary attack. Electrocardiogram was negative. The patient was given a sedative, and remained in bed. The following day mild cramp-like pains occurred at infrequent intervals. The pain was generalized throughout the abdomen. He then developed diarrhea. The condition seemed to be gradually subsiding as the day wore on. On the next day cramp-like pain occurred occasionally, temperature was 100, a blood count showed 19,000 white cells, with 82 per cent polymorphonuclears. Temperature remained at 100 for twenty-four hours and the pain came only infrequently and was generalized over the abdomen; now rigidity was noted and in the right lower quadrant. On very deep pressure, a tender mass, about the size of a grape was thought to be present. Rectal examination disclosed a tender fulness above the prostate. A surgeon of wide experience was consulted but he was doubtful of the diagnosis. Operation disclosed acute suppurative appendicitis.

This patient had had two previous attacks with similar onset, abortive in character, and clearing in 24 to 48 hours. A gastro-intestinal series of x-rays showed a retro-caecal appendix.

In this case, onset was diverting enough to cause the first physician to make a diagnosis of coronary disease. Thereafter little evidence pointing to appendicitis was found until several days after the onset and only with some localization of a suppurating appendix. Finally, (and only after the author's insistence) the surgeon agreed to operate. In my files on this case I have a letter of doubt as to the pre-operative findings by a surgeon of international repute. To his surprise, he found a ruptured localized appendix.

CONCLUSIONS

This article is written with the purpose of re-emphasizing the importance of keeping acute appendicitis in mind in every abdominal diagnostic difficulty. The atypical, acutely inflamed appendix is so different from the classical text-book picture that it is not only the neophyte who may overlook the diagnosis. The experienced surgeon with a background of many years is not infrequently amazed at his failure to make the proper pre-operative diagnosis of acute appendicitis.

40 Journal Square

STATE ACTIVITIES

BOARD OF TRUSTEES

A regular meeting of the Board of Trustees was held June 8, 1947, in Atlantic City.

Present were: Dr. Crowe, chairman, who presided; Dr. Allman, Dr. Fithian, Dr. Dodd, Dr. Coleman, Dr. Johnsen, Dr. Green, Dr. Lee, Dr. Costello, Dr. Schaaf, Dr. Sica, Dr. Wood, Dr. Hornberger. Dr. Lance was excused. Also present upon invitation were Drs. Read, Hurff, Lewis and Donohoe, A.M.A. Delegates; Dr. Scott, Dr. Londrigan, Dr. Quigley and Mr. Grimley.

Dr. Scott reported that, with postal approval from a majority of the Trustees of the pamphlet *Implementing the National Health Program of the A.M.A. in New Jersey,* 3,500 copies had been printed and forwarded to the A.M.A. Council on Medical Service for distribution. Included in the pamphlet are the Principles of Cooperation of The Medical Society of New Jersey with Health and Welfare Agencies.

Upon motion by Dr. Schaaf, seconded by Dr. Wood, and unanimously carried, the Trustees formally approved the *Principles of Cooperation* and the pamphlet. (See page 331.)

GROUP PRACTICE

At the request of Dr. Bensley of the Summit Medical Group, Dr. Scott presented the matter of a New York State resolution to the A.M.A. relative to group practice, which requests the A.M.A. to appoint a Bureau or Committee to formulate policies and principles governing group or partnership practice.

Upon motion by Dr. Schaaf, seconded by Dr. Costello, and unanimously carried, the A.M.A. Delegates were empowered to use their discretion in voting on this matter when it comes before the A.M.A. House of Delegates.

VETERANS CARE PLAN

Dr. Scott reported that the new contract between Medical Service Administration and the Veterans Administration had been submitted by VA for signature. The new contract does not contain provision for the existing salaried Liaison Officer and adjusts the fee schedule to what they term a "national basis". Medical Service Administration feels that there are other objectionable features about the new contract, in addition to these, such as that all physicians will be designated physicians.

Following discussion, Dr. Schaaf moved that the matter of the new contract between Medical Service Administration and the Veterans Administration be left to M.S.A., which would negotiate a suitable contract and add such items as they feel should be written into the contract. Seconded by Dr. Costello and carried.

COMMITTEE ON STUDY OF MEDICAL CARE

In accordance with the action of the House of Delegates that the President appoint a Special Committee on the Study of Medical Care, Dr. Schaaf reported he had appointed Dr. Scott, chairman, Dr. Butler, Dr. Blaugrund, Dr. Alexander, Dr. Quigley, Dr. Blaisdell and Dr. Murray. In addition two or three additional names have been mentioned as worthy additions to the committee. Dr. Schaaf requested permission to enlarge the committee.

Upon motion by Dr. Costello, seconded by Dr. Sica, and unanimously carried, Dr. Schaaf was authorized to increase the membership of this special committee to a limit of 12 if found necessary.

FEDERAL LEGISLATION

President Schaaf and Dr. Quigley reviewed for the information of the Trustees the Hearing on S-545 (Taft, Smith, Ball, Donnell bill) held in Washington on June 5, 1947, and attended by Drs. Schaaf, Quigley, Scott, Alexander, Hornberger and Butler. Dr. Quigley and Dr. Scott were commended for the preparation of the presentation—the statement by Dr. Quigley and the exhibits by Dr. Scott. Dr. Alexander read the statement.

Following the hearing all, except Dr. Hornberger, had luncheon with Dr. Marjorie Shearon and others. By mutual consent, Dr. Shearon has resigned as counsel to the majority group. She now plans to operate a Bureau of Information on federal legislation. Subscriptions to this will be $15 a year for individual subscribers, $200 for organizational subscriptions, and $500 a year for sustaining subscription. Organizational subscribers would be entitled to ten copies of each release; the "sustaining subscribers" to as many copies as desired plus additional information and perhaps personal research upon request. The group who attended the Washington hearing recommended the Society's taking a sustaining membership at $500 for one year.

Upon motion by Dr. Schaaf, seconded by Dr. Fithian and unanimously carried, the Trustees authorized the purchase of a sustaining subscription at $500 for one year to Dr. Shearon's service.

Upon recommendation of the Legislative Committee and the New Jersey representatives to the hearing in Washington on S-545, Dr. Schaaf requested that copies of the statement presented by New Jersey be printed and distributed to each member of the House of Delegates of the A.M.A. The Trustees concurred in this request.

Following discussion of present status of federal legislation, particularly S-545, (Taft, Smith, Ball, Donnell bill), and S-140. (Fulbright-Taft bill), the Trustees reiterated to the A.M.A. Delegates the Society's support of S-545 and opposition to S-140 and to the Wagner, Murray, Dingell bill.

FINANCE AND BUDGET COMMITTEE

Dr. Allman, Chairman of the Finance and Budget Committee presented the following recommendations:

Transfer of $25,000 from the Surplus account to the House Reserve Account for purchases and improvements on the Home under supervision of the House Committee; immediate purchase and improvements in the amount of approximately $5,000, as recommended by the House Committee to be authorized.

Upon motion by Dr. Allman, seconded by Dr. Sica, and unanimously carried, the Trustees authorized the transfer of $25,000 from the Surplus account to the House Reserve account, and the expenditure of $5,000 for immediate purchase and improvements.

Net profit from the 1947 annual meeting in the amount of $3,631.84 be held as a reserve for the 1948 annual meeting and not transferred into the general surplus.

Upon motion by Dr. Allman, seconded by Dr. Wood, and unanimously carried, the Trustees authorized the setting up of an Annual Meeting Reserve account for this year and the holding of the 1947 profit in the account.

That a wedding gift be authorized for Miss D'Arcy, recently married.

Upon motion by Dr. Schaaf, seconded by Dr. Sica, and unanimously carried, the Trustees authorized Mrs. Madden to purchase a suitable gift for Miss D'Arcy, in the name of the Society not to exceed $100.

That Dr. Scott be authorized to trade in his car and purchase a new one.

Upon motion by Dr. Allman, seconded by Dr. Sica, and unanimously carried, Dr. Scott was authorized to trade in his car, and purchase a new one the cash transaction not to exceed $1500.

SECTION ON METABOLISM

Dr. Schaaf presented a request from the newly formed New Jersey Diabetes Association for recognition as the Section on Metabolism under the General Medical Section at the annual meetings.

Upon motion by Dr. Schaaf, seconded by Dr. Dodd, and unanimously carried, the Trustees authorized the recognition of a Section on Metabolism as a sub-section of the General Section on Medicine and in conformity with previous action taken on requests from other specialized groups.

REPORT OF THE PRESIDENT

In addition to the many special matters presented by the President to the Board at this meeting, Dr. Schaaf reported on his activities since the Atlantic City meeting in April. Visits were made to meetings of the Hudson and Passaic County Medical Societies; attendance at the Middle Atlantic States Conference in Philadelphia, the Welfare meeting in Trenton, and the Senate Hearing on S-545 in Washington; addresses were made to the Essex County Auxiliary and the American Proctologic Society.

Dr. Schaaf gave a brief report on the Middle Atlantic States Conference held on May 23rd in Philadelphia, attended by Drs. Schaaf, Quigley, Scott, Butler and Kler. Dr. Kler made a presentation at the conference on the work of the Cancer Committee and the Cancer Society in New Jersey. It was well received and believed to be the best discussed report of the meeting. The New Jersey delegates were impressed with the fact that New Jersey is far more advanced in its thoughts and actions than any of the other states represented in the Conference.

EXECUTIVE OFFICER

Dr. Schaaf reported that the special committee was not yet ready to make definite recommendation of anyone to fill this position. Conferences have been held with the Executive Secretary of the Rhode Island Medical Society, and several suggestions as to possible candidates have been made by him. The Committee wishes to defer action on appointment for awhile until other sources have been explored.

Dr. Sica referred the Committee to Mr. Swart, Executive Assistant of the A.M.A., with whom he has talked, with regard to possible recommendations for the position. The Committee will interview Mr. Swart during the A.M.A. convention in Atlantic City.

OSTEOPATHIC PHYSICIANS

Dr. Schaaf reported that, in accordance with the March 16th action of the Board relative to inspection of the two approved osteopathic colleges by the A.M.A., the Board of Medical Examiners had received replies from both colleges refusing such inspection. The Board of Medical Examiners is willing to inspect the Philadelphia College this fall with an impartial educator.

It was Dr. Schaaf's belief as an officer of the State Society and as a member of the Board of Medical Examiners, and in view of the report of the Subcommittee on Legislation passed by the House of Delegates "that the present situation with respect to the crediting of osteopathic schools should be treated with caution. . . .", that the matter should be left status quo for the time being.

Dr. Johnsen opposed this viewpoint, stating that this issue could not be side-stepped forever, and that the Board should follow through its resolution of March 16, that if the schools refused to request inspection by the A.M.A. that the Board of Medical Examiners revoke their recognition as an accredited school.

Dr. Lee moved that the matter be left status quo for the time being. Seconded by Dr. Green and carried; Dr. Johnsen dissenting.

HEALTH COUNCIL

Dr. Schaaf submitted the following names for consideration in making recommendations to the Governor for appointment to the New Jersey State Department of Health in addition to those already submitted on April 24: Dr. George W. Fithian, Dr. Stanley Nichols and Dr. Wilson G. Guthrie.

Since the Board will not meet until September, and the Governor's request for recommendations might come in before that, Dr. Costello moved (seconded by Dr. Schaaf and unanimously carried), that a Committee consisting of the President, Chairman of the Board and immediate Vice-Presidents, act for the Board when and if the Governor requests the names of candidates.

WELFARE COMMITTEE RECOMMENDATIONS

Secretary Green read the following recommendations from the Welfare Committee:

That the revised article on *Workmen's Compensation and the General Practitioner* and Schedule of Disabilities be reprinted with a cover and mailed to each member of the Society.

Upon motion by Dr. Wood, seconded by Dr. Johnsen and unanimously carried, the Trustees concurred in this recommendation.

That the Trustees make an early selection of an Executive Officer.

This matter was referred to the special committee appointed for this purpose.

That an increase in the appropriation for the office of Executive Officer be made by the Trustees.

Upon motion by Dr. Sica, seconded by Dr. Wood, the Trustees concurred in this recommendation; increased appropriation to be made available when and if necessary.

That copies of the pamphlet *Implementing the National Health Program* be printed and distributed to the membership.

Upon motion by Dr. Schaaf, seconded by Dr. Johnsen and unanimously carried, the Trustees authorized the printing of sufficient copies of the pamphlet and the distribution of a copy to each member, and to other interested organizations and upon request.

DAVID W. GREEN, M.D.,
Secretary.

NEW JERSEYITE TO HEAD MENTAL DEFICIENCY ASSOCIATION

Lloyd Yepson, Ph.D., of Washington Crossing, N. J., was elected president of the American Association on Mental Deficiency at the 71st Annual Meeting of that organization held in St. Paul on May 27. Plans were made for an International Congress on Mental Deficiency to be held in Boston in May 1948, in celebration of the centennial of the first institution for mental defectives ever established in America.

MENTAL HYGIENE COMMITTEE

Under the chairmanship of Dr. Henry Cotton, the Advisory Committee on Mental Hygiene met in Newark on May 28, 1947.

Dr. Cotton recounted briefly the main accomplishments of the committee last year. These included:

1. Press releases on the subject of mental hygiene and on the need for more clinic facilities.

2. A recommendation that every general hospital in the state make provision for a neuropsychiatrist on its staff with the same standing as that of other medical specialists. In the smaller hospitals, this would have to be largely on an out-patient and consultation basis. In some of the larger hospitals it might be possible to set up in-patient services. The chairman met with officials of The Medical Society of New Jersey and also with the New Jersey Hospital Association and these recommendations were adopted by both groups.

3. It was recommended that each county society devote at least one program every year to the subject of mental hygiene and psychiatry. When this recommendation was made last year, it was not carried out in every instance, and it is planned to follow this up during the coming year.

4. A refresher course in psychiatry for general practitioners was given in Essex County through the efforts of Dr. Loeser and Dr. Robie.

Dr. Cotton said that the committee, as constituted for the coming year, included representatives of the three main groups of psychiatrists in the state; namely, the private practitioners, those associated with the Veterans Administration, and those associated with state and county institutions.

The following points were covered at the meeting:

1. It was felt that there was a need for continuing the educational program for general practitioners in the field of psychiatry and mental hygiene. Dr. Loeser reported that the course given in Essex County last year would probably be repeated and amplified during the coming year. It was further decided that Dr. Lynch would explore the possibilities of setting up such a course in Hudson County and that Dr. Cotton would do the same for Mercer County.

2. It was felt by the committee that the policy of having each county society devote one session a year to mental hygiene and phychiatry was a good one.

3. It was felt that education of the public in the field of mental hygiene is badly needed. However, inasmuch as the newly established Psychiatric Foundation is formulating a program along this line, it was decided to wait and see what they brought forth before initiating any local project.

4. The committee felt that there was need for legislation in this state to permit the commitment of alcoholics. In making this recommendation, the committee was fully aware of the present limitations at these institutions. However, it was felt that such legislation would be helpful in making it possible to get certain individuals who present severe alcoholic problems out of the communities and in hospital atmosphere. This recommendation will have to be carried through the Welfare and Legislative committees of the Medical Society.

5. There was considerable discussion of what to do with psychopathic personalities and defective delinquents. It was felt that some of these are a definite hazard to the communities and, under present laws, many of them cannot be held for more than short periods in the correctional institutions to which they are committed. The committee fully realized that there are many complications regarding the drafting of such legislation. However, they did go on record as recommending that steps be taken for the drafting of legislation to take care of severe defective delinquents. This recommendation will be passed on to the Legislative Committee of the Medical Society.

6. There was considerable discussion of the present form of the commitment papers used in this state. Dr. Robie recommended that instead of having two separate certificates to be filled in that there should be one certificate signed by two physicians. It was suggested that inasmuch as there is a Deputy Attorney General in Dr. Cotton's office that he draw up a new form and send it to each member of the committee for study and criticism and that after a form has been drafted which meets with the approval of all concerned that an attempt be made to have it put into general use.

7. The question was raised as to whether the New Jersey Neuropsychiatric Association should become a component part of The Medical Society of New Jersey. This matter was referred to Dr. Robie, the president of the New Jersey Neuropsychiatric and he is to make a report at a later date.

HENRY A. COTTON, JR., M.D.,
Chairman.

PRINCIPLES OF COOPERATION BETWEEN ORGANIZED MEDICINE AND HEALTH-WELFARE AGENCIES

In the past we have heard complaints to the effect that organized medicine has no positive, constructive program and that its approach to voluntary and official health and welfare agencies is a negative one.

The health and welfare agencies have their problems. Most of them are conscientiously trying to do something to improve the health of the indigent and low wage group. These efforts cannot be disregarded by the medical profession. To fear the activities of such agencies is evidence of weakness in medical organizations.

There are many ethical types of arrangements which may be made between organized medicine and these agencies to solve their problems "at a local level, to meet local need". Such arrangements may involve the allotment of specific amounts of money on a per capita basis to a county society, for which in return the members of the society agree to provide the medical care, such as is in operation in Topeka, Kansas. Other arrangements may involve the payment of physicians on a clinic-hour basis, such as is in operation in Monmouth County. A reimbursement plan, such as the Newark Medical Plan, may be the solution of some instances. There is nothing unethical about a physician or group of physicians working on a salary basis. Some form of ethical cooperative agreement, involving a health agency, a group of eligible persons, and organized medicine, should be possible of evolution to meet any medical care distribution problem. But, whatever arrangement is made, it should have the approval and support of organized medicine, and organized medicine must assume responsibilities for maintaining adequate standards of medical care and the control of abuses.

The following "principles of cooperation" introduced by the New Jersey delegates, as adopted by the A. M. A. House of Delegates in June 1947, offer a positive approach to these agencies, assure control of the program by organized medicine, and we believe are adaptable to any community.

1. Each component society will appoint the necessary committees to study the public health and medical care problems and to supervise projects relevant to these problems.

2. Each component society pledges itself to maintain a high standard of professional skills among the medical personnel assigned to these projects, and to supervise such activities with a view toward maintaining high scientific standards and preventing personal exploitation.

3. Each component society invites and welcomes, at its discretion, the active participation in its scientific programs by the qualified medical personnel of the appropriate health and welfare agencies, and, under suitable circumstances, of the desirable nonmedical personnel as well.

4. The health and welfare agencies will render genuine cooperation with each component society in the implementation of these projects.

5. The health and welfare agencies will select their part-time medical personnel from lists furnished by, or with the approval of, each component society.

6. The health and welfare agencies will clear through each component society any grievances concerning medical personnel.

7. The health and welfare agencies will protect the private practitioner and family doctor by discouraging treatment in preventive clinics, by returning to the family doctor any cases not economically suitable for examination or care at the health or welfare agency.

8. The health and welfare agencies will not profit financially by the labors of any medical personnel working there.

9. Each component society and the health and welfare agencies will seek the cooperation of dental, nursing and pharmaceutical organizations in a program fashioned to accord with these principles.

10. Each component society and the health and welfare agencies will maintain continuing liaison with each other to implement these principles.

RESOLUTIONS ADOPTED BY THE A. M. A. IN JUNE 1947

The following resolutions were adopted by the House of Delegates of the A.M.A.:

1. A two-day scientific session for general practitioners at the time of the semi-annual meeting of the House of Delegates.

2. Change of meeting place for the semi-annual session—to convene in a different geographic district each year—at which time the two-day session for general practitioners would be held.

3. Closer affiliation with third and fourth year medical students—possibly by affiliate membership—and reestablishment of a student section in The Journal, and encouragement of presentation of scientific papers at county, state and even national levels; also to study the possibility of a student section of the scientific assembly.

4. The Secretary, in collaboration with the councils and bureaus, to prepare an attractively illustrated booklet describing the various activities carried on by the Association for distribution to graduating medical classes.

5. Further clarification of public relations activities of the Association.

6. More experienced representatives as speakers for lay groups and legislative bodies, and the establishment of a speakers' bureau to assist those representatives.

7. Greater utilization of the Woman's Auxiliary as an instrument in the field of public relations.

8. Establishment of a Committee on Nursing Problems.

9. Better channeling of information to the House of Delegates of the activities of departments, bureaus and councils.

10. Active cooperation by the Association with governmental officials to work out a program for prompt medical service in case of another national emergency.

11. The House of Delegates to take under advisement a building program for the Association headquarters.

12. The Council on Medical Education and Hospitals adopted new standards for residencies and fellowships in the specialties.

SUPPLEMENTARY LIST NO. 3 TO THE 1947 OFFICIAL LIST

Blum, Milton, 41 Tonnele av., Jersey City (9)
Brophy, Francis X., 55 Gifford av., Jersey City (9)
Bruning, Richard H., 372 Wyoming av., Maplew'd(7)
Champlin, Paul M., 12 Lenox av., East Orange (7)
Cordasco, Peter, 517 Roseville av., Newark (7)
Dedick, Andrew P., Jr., 118 Branch av.,Red Band(13)
DeFuccio, Charles P., 12 Duncan av., Jersey City (9)
Diskan, Samuel M., 1616 Pacific av., Atlantic C. (1)
Fortunato, Joseph F., 224 Van Buren st., Newark(7)
Frank, Ulysses M., 670 Clinton av., Newark (7)
Ged, Archie K., 1133 Main st., Paterson (16)
Geller, Samuel, 696 High st., Newark (7)
Goldstein, Joseph D., 2801 Blvd., Jersey City (9)
Greene, Harry, 90 Duncan av., Jersey City (9)
Hathaway, George, 149 Prospect st., Passaic (16)
Heisen, Aaron J., Imlaystown (13)
Hirsch, Solomon, 895 Bergen av., Jersey City (9)
Hummel, Frederick W., 606 F st., Belmar (13)
Jensen, Grover H., 130 Jewett av., Jersey City (9)
Klein, Alfred, 1 Rue de la Marne, Rabat, Africa (9)
Lang, Joseph T., 115 Main st., South River (12)
Legg, George E., 666 Broadway, Paterson (16)
Lustig, Melvin, 137 Lyons av., Newark (7)
Mabee, John R., 24 Center st., Little Falls (16)
Manno, Peter D., 843 Boulevard, Bayonne (9)
Mansfield, Richard, 435 - 59th st., West New York(9)
Monte, Thomas D., 213 Park st., Montclair (7)
Neals, Huerta C., 130 Atlantic st., Jersey City (9)
O'Gorman, Michael W., 30 Baldwin av., Jer. City(9)
Parell, George D., 275 S. 7th st., Newark (7)
Rabinowitz, Jacob H., 25 Randolph pl., Newark (7)
Raphael, Chester M., State Hospital, Marlboro (13)
Richardson, Arthur H., 60 Orange rd., Montclair (7)
Rosenberg, Albert B., 120 Crescent av., Plainfield(9)
Salerno, Louis, 973 Van Houten av., Clinton (16)
Schneider, Leonard, 618 Brinley av., Bradley B.(13)
Schneider, Richard C., 874 S. 13th st., Newark (7)
Shack, David N., 712 Clinton av., Newark (7)
Silver, Michael W., 718 E. 25th st., Paterson (16)
Sorett, Joseph, 299 Broadway, Newark (7)
Stern, David A., 127 Lyons av., Newark (7)
Tepper, Victor, 2 Parkview ter., Newark (7)
Thompson, Victor, 80 W. Front st., Keyport (13)
Tilton, William R., 763 Broad st., Newark (7)
Verga, Armand, 20 Main st., Manasquan (13)
Wade, Francis A., 196 South st., Morristown (14)

ASSOCIATE MEMBERS

Boogdanian, Victor H., 316 George st., New Brunswick (12)
Kluft, Jack M., 84 Harrison pl., Perth Amboy (12)
Langgaard, Charles E., 517 South Livingston av., Livingston (7)

WHEN ON VACATION—

Physicians are reminded of the wisdom of notifying the Veterans Administration when departing on vacation. Reason: the VA may authorize visits to your office during the period of your absence, and if the patient can not come until after your return, the authorization may have expired. A phone call, postcard or letter to Chief, Outpatient Section, will do the trick. The address is 20 Washington Place, Newark 2, N. J.

VETERANS CARE PLAN

When a veteran desires readjustment of his compensation rating he is asked to have his private physician write on his letter-head a simple factual account of the history and nature of the defect. This is the medical evidence, without which VA cannot reconsider the claim. In rendering this service, private physicians do not bill the VA.

PROGRESS REPORTS

The Veterans Administration "sick-bay" of New Jersey is bounded on the east by the Atlantic Ocean, on the south, etc. "Ward Officers" and specialists use their own offices and local hospitals to render medical care to eligible veterans. All physicians of The Medical Society participate.

VA has not supported the home-town program with an attitude of "hospital managers"; four-hour temperature charts and nurses' notes are not required for veterans treated at home or in the physician's office.

Nor is the "sick-bay" open to all veterans. Only those who have been rated by the VA as having service-connected or service-aggravated defects may enter. After determining the eligibility of a veteran, VA must tell the physician how much treatment it will pay for. Only the Regional and Sub-Regional Offices of VA possess this authority.*

When the treatment period of a calendar month has been completed, the physician is required to submit a progress report as well as his bill to VA. This report should contain a brief description of the veteran's defect, the kind of treatment he has received and the progress he has made. This is the only clinical record required by VA.

Contact Offices do not possess authority to grant medical care to veterans through private physicians. They serve as intermediaries, available for advice.

THE CHANGING SCENE

For administrative reasons, physicians have been notified that they will not be restricted to a book-keeping limitation of $500 income a month, but rather that the $6000 annual income limitation will prevail. A physician becomes temporarily ineligible to treat veterans when his income from VA reaches $6000, except by special review of the situation in Washington, D. C.

VA PART-TIME PHYSICIANS

Thirty-eight former part-time physicians with the VA, all veterans, who resigned to maintain private practice, were restored to The Medical Society list of participating physicians by VA after having been removed because of a ruling that resigning employees may not be appointed to another capacity with VA until a lapse of two years. The Liaison Officer communicated with Dr. Hawley, who replied that VA could not subsidize physicians, although the retroactive feature was removed and those physicians restored.

VA'S FORM LETTERS

The volume of business conducted by VA makes form letters necessary. The form letter has been one of the answers to the problem of beating back-logs. Great stress has been laid on immediate handling of requests from physicians to treat veterans.. VA efficiency is hurt when physicians do not conform to the details on the forms they submit. VA concessions on policy cannot be allowed. Individually dictated letters are impossible.

The form letters have been designed to notify the physician and to instruct him. Occasionally the physician becomes confused because they do not fit the bill. Although a business evil, form letters help VA get its work done.

THE OLD ROUTINE

Notify VA immediately in writing that a veteran, your patient, seeks medical care, describing the nature of his defect, the kind of treatment proposed and the probable number of visits for the remainder of the month. Once you have established communication with VA, forms will be sent to you. VA cannot pay for treatment rendered more than 15 days prior to their receiving notification. But wait for VA to authorize the treatment. In an emergency, phone VA collect.*

NEW BILLING METHOD

The new method of billing on the reverse side of the authorization should be done in such a manner that the Veterans Administration receives from the physician an *original bill* of his typing and not the original VA authorization. Two carbon copies of the bill are not acceptable for payment. The physician retains the original VA authorization, and on the reverse side should be a carbon copy of his billing.

Edward T. Yorke, M.D.,
Liaison Officer.

* Newark, Trenton and Union City.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

New Jersey's first Public Health Council appointed by Governor Alfred E. Driscoll and confirmed by the Senate at a special session on June 30, assumed its duties under Chapter 177, P.L. 1947 on July 1.

Members of the first Council are: Dr. Harvey N. Davis, of Hoboken, President, Stevens Institute of Technology, for a term of one year; Mr. Wheeler McMillen, of Hopewell, Editor, Farm Journal, for a term of two years; Dr. Frederick P. Lee, of Paterson, Health Officer, City of Paterson, for a term of three years; Dr. Walter G. Alexander, of Orange, practicing physician, for a term of four years; Dr. Marcus W. Newcomb, of Browns Mills, Medical Director, Fairview Sanatorium, for a term of five years; Mrs. Florence M. Farr, of Brookside, member and former president, Citizen Health Council, for a term of six years and Harry N. Lendall, Chairman, Department of Civil Engineering, Rutgers University for a term of seven years.

Dr. Davis was born in Providence, R. I., and received A.B. and A.M. degrees from Brown University, and A.M. and Ph.D. degrees from Harvard University, the latter in 1906. He has been president of Stevens Institute of Technology since 1928. Dr. Davis was Director of the Office of Production Research and Development of the War Production Board from 1942 to 1944.

Mr. McMillen is Editor-in-Chief of Farm Journal, Philadelphia, and editorial director of Pathfinder, Washington News magazine. Industrial and scientific circles know Mr. McMillen as President of the National Farm Chemurgic Council. The Council is devoted to advancing the industrial uses of farm products through applied science. Newspaper man and public speaker, Mr. McMillen is a native of Hardin County, Ohio.

Dr. Lee, a member of the former State Board of Health and its President from July 1, 1945, to the date of its expiration, June 30, 1947, is Paterson's Health Officer and brings a wealth of experience to the Council. After service as Health Officer of New Britain, Conn., the city of his birth, Dr. Lee became Paterson's first full time Health Officer in 1923. Paterson's progressive health measures carry the imprint of Dr. Lee's administration as Health Officer. Tuberculin-testing of herds, pasteurization of milk, were outstanding accomplishments. He was author of the statute for prenatal blood examinations and collaborated in effectuation of the law for premarital examinations.

Dr. Alexander was originally appointed to the former State Board of Health in 1939, and reappointed in 1943, serving as Vice-President, 1946-47. His experience and activities as a member of the State Board of Health have provided him with a sound background in the public health needs of New Jersey. A native of Lynchburg, Va., Dr. Alexander was graduated from Lincoln University in 1889, Magna Cum Laude, as the first student of his class. In 1903, he graduated from the College of Physicians and Surgeons and practiced his profession for one year in Kimball, West Va. Locating in Orange, N. J., in 1904, Dr. Alexander has been active in medical, civic and professional fields in New Jersey. Elected to the House of Assembly in 1920, he was the first Negro to attain that office in New Jersey. Re-elected in 1921, he served as temporary Speaker of the House of Assembly, the first time a Negro had acted in that capacity in any northern state. His alma mater, Lincoln University, awarded him the honorary degree of Doctor of Humane Letters in 1939.

Dr. Newcomb, a former Speaker of the New Jersey House of Assembly, has devoted his talents to arresting tuberculosis since 1912. He has been superintendent of Fairview Sanatorium since 1919. Also, he is Medical Director of the Manor Nursing Cottage, Browns Mills, N. J., and Consultant to the Burlington County Hospital and Deborah Sanatorium.

Mrs. Farr has been interested in public health from her early experience as a volunteer in a baby clinic in Providence, R. I. She is a native of Westerly, R. I., and graduated with an A.B. degree from Smith College. During the past twenty years, she has gained extensive knowledge of community health problems in New Jersey through membership on numerous boards and committees. Mrs. Farr was instrumental in 1944 in forming the Citizen Health Council in N. J., and was its first Chairman.

Professor Lendall, civil engineer, is Chairman of the Department of Civil Engineering and Professor of Municipal and Sanitary Engineering at Rutgers University. He served as a member of the former State Board of Health from September 30, 1946, until creation of the Public Health Council. Professor Lendall has been associated with Rutgers University for more than 30 years and has been actively engaged in engineering work in New Jersey and elsewhere.

WOMAN'S AUXILIARY

ACCOMPLISHMENTS OF THE AUXILIARY

On June 16, 1947, Dr. William E. Dodd and Mrs. Lodovico Mancusi-Ungaro, spoke over radio station WTTM. An abstract of the talks follows:

DR. DODD'S ADDRESS

The Medical Society of New Jersey was founded in 1766. All through these 181 years, the efforts of the doctors have been aided by that indispensable citizen of every community —The Doctor's Wife. To her the doctor has turned for encouragement and inspiration. To her the community looks for counsel and guidance in a thousand and one little ways, which may be unimportant individually but which add up to a very important community service. In many instances the doctor's wife is closer to the personal side of the practice of medicine than the doctor himself. Her interest in all matters pertaining to the welfare of the community is keen. Long ago she realized that her individual efforts were not enough. She realized that by uniting with other doctors' wives throughout the country an organization could be created whose unity of purpose could accomplish far greater good than she could alone. So came into being the Woman's Auxiliary. Twenty-five years ago an Auxiliary was formed in connection with the American Medical Association, and three years later The Medical Society of New Jersey organized its Woman's Auxiliary. Members of the national organization number more than 35,000. It is made up of the wives, mothers and unmarried sisters of the doctors of the United States, who belong to medical societies. Forty-two of our forty-eight states have a Woman's Auxiliary, most of the counties throughout the union have county medical societies and corresponding woman's auxiliaries. Thus, this far reaching organization extends from a national level down through the states into nearly every county and community. It is made up of self-sacrificing, public-spirited women who put the welfare of their community, state and nation before their own personal comfort. It is in no way a political organization, but its members are vitally interested in any legislation which has a direct bearing upon the public health and the welfare of the community.

The activities of the organization were social at first, but soon expanded into the field of public service. Let me tell you some of the things that this Woman's Auxiliary in your state has done and is doing.

JUVENILE DELINQUENCY

It has recognized the problem of juvenile delinquency and by the promotion of discussion groups throughout the state has striven, with such organizations as the Parent-Teachers Association, to get at the origin of local conditions which contribute to the problem and has been active in formulating corrective measures.

ACCIDENT PREVENTION

As our civilization becomes more complex, machines and devices designed to benefit mankind have often become the means by which a person is injured or killed. The number of accidents occurring each year is appalling and a large number of them occur in the home. The Woman's Auxiliary in conjunction with the National Safety Council has taken an active part in the campaign of accident prevention. Its influence has been especially directed toward the prevention of accidents to children and toward the prevention of accidents in the home.

PUBLIC HEALTH

The Woman's Auxiliary to The Medical Society of New Jersey has been interested and active in many phases of public health. Tuberculosis, heart disease, maternal and child health have engaged its attention. It has carried on a program to bring reliable health information to the public. Through the medium of the American Medical Association's health journal, *Hygeia,* this knowledge has been brought into public libraries, schools and homes.

THE VETERAN

The doctors who accompanied our armed forces through battle and cared for them during those trying years have largely returned to civilian practice or graduate study. On returning home, many problems faced them. The Woman's Auxiliary was among the first to welcome them and has been active in many ways in getting the physician-veteran reestablished in practice. The Auxiliary has also been mindful of the non-medical veteran. In-

dividually, the "doctor's wife" has done much to solve the personal problems of these boys, and in many instances those of their newly wedded wives.

BLOOD DONOR SERVICE

In Ocean County there was need for a blood donor service to make available to those who needed blood transfusions a donor, on quick notice, whose blood had already been typed and tested, and in whose past there was no history of malaria or any other condition which would make that blood unsuitable for transfusion. The Woman's Auxiliary of the Ocean County Medical Society organized such a service. They recruited donors, saw to it that every safeguard was thrown around both donor and recipient by laboratory tests, careful history, and suitable physical examination of the donors. Thus, a patient needing a transfusion was assured that the blood he was to receive was of proper type and purity. No longer, when emergencies occurred in the middle of the night, need a doctor search vainly for a donor whose blood would match that of his patient who lay next to death's door from a severe hemorrhage. The Woman's Auxiliary Donors Service was prepared beforehand. They knew where the proper donor lived, whether he was available, and how he could be reached. They even provided means of paying the donor a small fee for giving his blood.

This is but an example of what the local county auxiliaries are doing. In each county the local chapter has turned itself to its county needs and are at work. Today the state organization is concerning itself with problems affecting public health and meeting for the purpose of discussing these matters with representatives from other interested women's organizations. Let me introduce Mrs. Frances Mancusi-Ungaro, president of the Woman's Auxiliary to The Medical Society of New Jersey, who will tell you about today's activities.

MRS. MANCUSI-UNGARO'S ADDRESS

In addition to the program in Ocean County, the Monmouth County Auxiliary too has set up a blood bank, and Essex Auxiliary is preparing to aid in this work this fall. Gloucester's Auxiliary bought a ceiling projector for the patients at Tilton General Hospital—for the men who lie flat on their backs. Atlantic planned parties for the crippled children at the Betty Bacharach Hospital. Camden and Burlington give scholarships for nurses each year. Passaic two years ago saw that there was no place in the county to treat children stricken with rheumatic heart disease and are raising funds for a rheumatic heart foundation. Warren's Auxiliary buys equipment for its rural hospital, and Middlesex for its laboratory. Mercer and Essex operate health forums on a local level.

In a quiet way this organization has been doing a tremendous amount of good throughout the state.

But we do not feel that this is enough. There are many problems yet unsolved in the field of health education—problems which are not peculiar to party, color, race, or creed. For this reason it seems logical that the Auxiliary of an organization devoted to the public welfare regardless of color, party, race, or creed, should take an interest in problems of the health of our state.

We have called together the leaders in many fields to discuss some of these problems, and anyone who is interested is welcome to come and listen, and to participate in these informal discussions.

HEALTH EDUCATION PROGRAM OF THE WOMAN'S AUXILIARY

PUBLIC RELATIONS COMMITTEE

MRS. ASHER YAGUDA, Chairman

Fifteen hundred invitations were sent to representatives of women's groups, to educators, hospital administrators, the clergy, to state and municipal officials and to social, public health and welfare groups to attend a Health Education Forum on June 16, 1947, at the Executive Offices of The Medical Society of New Jersey. Capacity audiences attended the all day sessions.

Advance publicity was obtained through twenty-one newspapers plus one and three-quarter hours free radio time on Newark and Trenton stations. Follow-up publicity was given the program by fifteen state newspapers, as well as by the New York *Times*, the New York *Herald Tribune* and the Philadelphia *Inquirer*. The July issue of *Public Health News* devoted three and one half pages to a

full reporting of the meeting. Dr. Emil Frankel, at a public relations forum in Princeton, cited the program as a noteworthy, modern approach to medical public relations work.

The president of the Woman's Auxiliary to the American Medical Association attended.

The United States Department of Labor relinquished fifteen minutes of radio time on the day of the meeting to make it possible for the committee to broadcast a discussion by four members of the panel on "The Health of Women in Industry".

The following material has been abstracted from the actual panel discussions, which were transcribed, and Dr. Smiley's speech has been condensed for THE JOURNAL.

Dr. Dean F. Smiley of Chicago, principal speaker of the afternoon, urged the formation of community health councils to meet local needs and efforts to make the benefits of modern medical knowledge available to all. As steps toward that end, he recommended extension of full-time health service, with rural areas organized in units of 50,000 population, and a comprehensive hospital building program, with aid through the Hospital Construction Act of 1946.

"About forty per cent of the rural counties in this country have no hospital within their borders," said the speaker. "I don't minimize the difficulty of maintaining a hospital in a small community, but we must do it."

Dr. Smiley, who is consultant in health and physical fitness, Bureau of Health Education of the American Medical Association, also urged furtherance of prepaid medical and surgical care by voluntary insurance. He reported that the Blue Cross Hospital Service Plan is flourishing in 46 states and that the Medical-Surgical Plan is "a going concern in 36 states."

PANEL ON ALCOHOLISM

THE PANEL: The chairman was a member of Alcoholics Anonymous. Other members of the panel were: Mr. Nathan Davis, Assistant Deputy Commissioner, Alcoholic Beverage Commission, State of New Jersey; Dr. Henry A. Cotton, Jr., Deputy Commissioner, New Jersey State Department of Institutions and Agencies, Dr. W. D. Silkworth, Consulting Physician, Knickerbocker Hospital and Miss Ila Phillips from the National Committee for Education in Alcoholism.

CHAIRMAN: Perhaps Mr. Davis could give us some light on just where we stand in the law. The various movements in alcoholism are not going to do much without the cooperation of the medical fraternities. We need their ideas and their hospitals. License fees from liquor dealers are collected on the legal theory that the industry imposes an additional burden on the public.

MR. DAVIS: It might be well to learn first just what the liquor licensing in the state is. In New Jersey, we have a system which licenses all commercial activities. The problem of the alcoholic revolves around the retail licensee primarily. There are about 13,000 retail liquor establishments in the state. New Jersey gets a dollar or more a gallon for all alcoholic beverages sold. Very little of that money has been devoted to any problem of alcoholism. The Department of Alcoholic Beverage Control has taken the position that the problem of the alcoholic is really one of prevention and of rehabilitation of the individual alcoholic.

DR. COTTON: Psychiatrists and mental hygienists feel that alcoholism is primarily a mental hygienic and sociologic problem. Alcoholics are sick people. We don't feel alcoholism is a specific disease so much as we think that it is a symptom complex somewhat similar to anemia in medicine. The medical profession has been lax in not bringing forth a better program for the handling of this problem in the past. Many alcoholics can be helped and are being helped all the time; but the point I want to get across is that the alcoholic is a person who is in need of treatment. Alcoholism is evidence of an underlying maladjustment or immaturity or of the inability of that person to cope with the problems of life in a constructive and well adjusted manner. An alcoholic permits alcohol to interfere with one of his three major spheres of influence: family circle, professional or business career and general social or community adjustment.

The psychiatrist and those of us who specialize in the field do not think that alcohol makes an alcoholic any more than an automobile makes a reckless driver. In New Jersey, it is estimated that there are about 30,000 pathologic alcoholics. Facilities for the care of these people are tremendously limited if not, non-existent. The greatest credit in the treatment program so far must go to *Alcoholics Anonymous*. Their greatest value is in what is known as a "practical group psychotherapy". They have approached us a number of times and asked what could be done in terms of actual institutional facilities, because there are individuals in various stages of alcoholism who are not ready for the group movement which Alcoholics Anonymous provides.

When Governor Driscoll was Commissioner of the ABC, he formed a commission which issued a very comprehensive report in Feb-

ruary 1947, on the medical aspect of alcoholism in New Jersey. It was the opinion of all concerned that professionally there were two things needed at least. One, was need for either a special institution or special ward in the general hospital which would admit alcoholics in relatively acute stages, give them first medical treatment which was necessary and then start the psychiatric treatment which would be carried on later in the community. Secondly, there was needed a series of information centers wherein individuals or relatives of individuals suffering from alcoholism could come and get proper literature on the subject and be referred to the proper institution or proper facilities.

The tendency in public health today is for the laity to take the initiative in developing the facilities that the professional people tell them are needed. In the mental hygiene field and particularly in the alcoholic phase of it, we haven't in the past gone after the laity until recent years at least.

We do need in your general hospitals certain special wards, where these people can be sent for intelligent and constructive treatment in the more acute phases passing on into the long term therapy either with or without psychiatric help. Too many doctors think of alcoholics only in terms of cirrhosis of the liver or fatty degeneration of the heart or something like that.

CHAIRMAN: I don't think anywhere there has been such a firm wall to batter down as there is in alcoholism. The idea of character weakness has entrenched itself into the public mind so firmly that they are unwilling to take the constructive attitude needed to meet this problem. The question is not only as to how to educate, but it concerns the entire educational program and how it is to be handled and met.

DR. SILKWORTH: If prevention is better than cure, and we all know it is, then it follows that we must have some way of recognizing the potential alcoholic. And in fact there are some definite signs and symptoms by which it is possible for a drinker to recognize that he is, or might be, on the road to alcoholism. If the patient could be apprised of that he might avoid the hardships of alcohol-sickness. Unfortunately the newspaper and magazine articles on the subject are not always helpful. Some agency should have the responsibility of showing clearly the initial symptoms of alcoholism.

Two years ago, we in the Knickerbocker Hospital started a program to help the alcoholic. The expense was minimal. The same thing could be started right here in New Jersey in any good hospital. It will work if it is started with the right idea that the hospital itself accepts the responsibility of these people from any fixed point of view, and these people pay the hospital themselves.

CHAIRMAN: There are varying ideas of hospitalization. Some people think that we ought to have hospitals devoted exclusively to alcoholism; others think that we ought to have wards in the general hospitals financed in part by the patients themselves where they are able to pay the fees. However we have millions of license fees collected from this business which, in all theory of the license law, should go to pay for this treatment. Personally I think it is better to have special wards in general hospitals because it would mean better service. Rehabilitation, generally speaking, would be more easily accomplished if you had wards scattered in the various hospitals throughout the state.

DR. SILKWORTH: I favor the small unit and not the large hospital devoted exclusively to alcoholism.

CHAIRMAN: In *Alcoholics Anonymous,* we have 50,000 members coming back, getting well adjusted to society. That is surely some evidence to the public that alcoholism and alcoholics are not hopeless persons. If real education is to come with any quickness, it must come from the medical profession. The public properly follows the medical profession in their medical views. But how can we get the medical profession to take the positions necessary to educate the public properly on this question?

DR. COTTON: I am not entirely in accord with that plan of accomplishing the education. I think it must be a combined effort. After all, there are aspects to alcoholism which are not entirely medical. Why not the formation of a national organization which might be called an association for the prevention and treatment of alcoholism or something of that nature? This national organization should include a board of directors who would be leaders in the medical and particularly the psychiatric specialty, some sociologists, welfare workers, representatives of the clergy and influential laymen. It should be broken down into state chapters. Each state chapter should have a non-medical person as its chairman. Public spirited persons who would have the close and continued advice of the medical profession. These organizations would have to raise money just as cancer and the infantile paralysis groups have done and that is not always easy. To raise

money for alcoholism is not as easy as some of the other things. The educational program should include the distribution of literature on the subject. There is increasing interest on the part of the public as evidenced by the round table discussion today. They are in the mood to have a constructive program, and I feel it can be worked out.

CHAIRMAN: Nobody fears being drunk. They do fear cancer. They do fear tuberculosis. It is pretty hard to educate the public on the program.

MRS. PHILLIPS: In connection with the National Committee for Education on Alcoholism, our objectives are explicit in that title. We want to educate the public. We are sponsored by Yale University. We are a national committee and hope you will get local communities interested in their community responsibility. We have 22 such local committees throughout the country. It is a sociologic problem. It is a business problem. It is a medical problem. We get the information centers going. We want these information centers to send out speakers to the high school groups and let them know what these symptoms are. We have observed in the towns where we have these information centers, that these general hospitals are opening up. Doctors arouse the right kind of interest in the hospital and bring it about whereby the hospital will open up at least a few beds. We have a plan of community action right now we can present to any group that is interested to get them started.

CHAIRMAN: (In summarizing) When a man is under the influence of alcohol, it is impossible to advance any program for the reintegration of the personality or any arguments for the retaining of purpose in life. Unless he is hospitalized and cleared up, these arguments cannot be presented to him. Hospitalization is almost unknown in New Jersey. Some hospitals are giving us some support, but in general, hospitalization for alcoholism in New Jersey is very inadequate.

The problem of educating the public is difficult because people regard alcoholism as a character weakness and not as an illness as it is generally agreed to be among doctors. There is a remedy and the public should give more help. The way back is comparatively simple and easy to attain for anyone who wants to follow the path.

TRAFFIC ACCIDENTS OF CHILDREN

PANEL: Chairman: Colonel Charles H. Schoeffel, Superintendent, New Jersey State Police; Mrs. Daniel Reifsneider, Chairman, Safety Commlttee, New Jersey Congress of Parents and Teachers; Chief Ryan Vandervalk, President, Police Chiefs Association of New Jersey; Mr. Stanley Merrill, Deputy Regional Scout Executive of the Boy Scouts of America; Mr. Matthew Bolger, Director, Public Safety, New Jersey State Safety Council; John S. Herron, Superintendent of Schools of Newark, and Dr. Harrison Martland, Medical Examiner for Essex County.

CHAIRMAN: The state is doing a considerably better job in child education than we are in adult education. That is definitely shown by the statistical data. The police generally—I am talking now on state, county and municipal levels—have been in the schools for some 15 to 20 years lecturing before the student bodies on the subject of safety, and not only on motor vehicle safety but on all types of safety. As the summer season approaches, we talk about automobile accidents.

We have in the police field a corps of school safety patrols. The city problem is a little different than the rural problem in some instances. We do not believe in placing children in the middle of the street to direct traffic. The idea is to have the children who are in charge stand on the corner of the intersections and, when traffic has subsided to a point where it is safe, to allow the children to cross the street or send them across in groups.

We have also arranged for the supervision of children getting on and getting off buses. We have also arranged for the supervision of children at play.

Here are some of the factors that have been responsible for child deaths and child injuries as they affect the automobile. These statistics are purely on the pedestrian level.

There was a total of 2328 children killed or injured in traffic accidents in this state in 1946. The things that we have got to consider here as being the more dangerous are the following: Crossing between intersections, coming from behind parked cars, running from the sidewalk into the street, and playing in the roadway.

DR. HERRON: From the point of the schools and education, our work primarily with youth is to condition them to the dangers of the street. In other words, we are trying throughout our work to make them think. We are trying to put old heads on their shoulders.

The City of Newark initiated the safety patrols. We had the first school safety patrol in the country. Every sort of appeal is being made to our children, visualization, through the movies, through the radio, through art.

We get all the reports and diagnosis of the accidents and deaths in Newark about four

times a year, and get out a two or three page brochure. That goes to all the teachers so that the teachers can have it in hand. They use those up-to-date statistics to motivate their teaching.

We made a survey of the traffic problems around our schools in our city four years ago. We noticed a great deal of parking of cars in and around our schools. We erected about 600 "No Parking" signs to safeguard the lives of these boys and girls going to and from schools.

Last week we set out in conditioning the fathers, mothers and the motorists of the city in the matter of dangers in the summer-time when the schools are out. For the city of Newark the accident record to children was the lowest of any community in Essex County.

Mrs. Reifsneider: I am trying awfully hard to get every local association to have a safety chairman and to bring safety at every meeting. There are the classical three "E's": engineering, enforcement and education. I would like to tell you the other one. That is example; little children learn most from example.

We had to educate you parents even to put safety on their program.

Dr. Martland: As pedestrians, in Essex County in 1946, 41 children under 13 years of age were killed by automobiles. This is surely a slaughter of the innocent. And in 1930, we had 138 fatal auto cases of which 40 were children. That was in the period of prohibition. This is also a problem now because we have found on analysis of the brains that 20 per cent of pedestrians killed on the street were drunk in our area. That shows the importance of alcohol in traffic accidents. And no matter what you do with the State Police and education in the schools and everything else, it is the general moral attitude of the whole country. The greatest problem is the moron part of the population. We can't get away from that.

Mr. Merrill: The Boy Scouts of America consider health and safety so important that they have one of their six major operating committees called the Health and Safety Committee. The program is not designed to be complete without local agencies. We start the training of the boys in the cub work. And the material in the cub book is developed on the pattern of copy worked out by the National Safety Council and used by police and school authorities.

When the boy gets into scouting he gets additional safety instruction through regular requirements and special work in hiking, safety and cycling merit badges.

We have a very complete first-aid program which is developed now. The first instruction is to get a doctor; and the second one is not to move the patient if you can possibly avoid it.

Chief Vandervalk: I can discuss it on the basis of a city of 10,000 bordering on a city of 140,000. Most of my accidents are bicycles. We have registered in our headquarters about 2000 bicycles. That is all done on a voluntary basis. We do find these children like to go in there and register their bicycles. We give them a card and on that card there are their two thumb prints. They sign their name and on the back is the description of the bicycle and the serial number. We keep one card and they keep the other. They delight in having that registration card with them.

We also give them a booklet explaining the proper way of operating that bicycle. The whole trouble is that the parents don't seem to caution these children on the use of bicycles. The best way to educate these children with bicycles is to impound that bicycle for about 30 days.

Chairman: We, as a group, could start a movement to open up parks and parkways for the use of the children where they could use their bicycles. We would get somewheres. This group as a unit might take under consideration some special legislation where it is possible to do it, whether by state legislation or city ordinance.

Mr. Bolger: I note in the 1946 edition of *Accidents and Facts* by the National Safety Council that the school age (5 to 14 year) rate was 25 per cent less than in 1922, in which the National Safety Education program was begun, while the rate for older age groups increased 6 per cent from 1922 to 1945. It has been many, many years since a child was killed where a safety patrol boy or girl was on duty.

There will have to be some very serious consideration given not only to an increase in recreation facilities but an increase in "teaching to swim" contests. The *Learn to Swim* program is important. It gives a definite program for the summer season. If you get them to swim, of course, you can always remember the old saying about cleanliness and Godliness. Perhaps we can keep their bodies clean and we can keep their minds clean. It also has a definite value as a deterrent for juvenile delinquency.

We also do some educational work with commercial drivers. Recently we concluded a series of five Tuesday meetings, two hours

a night for five weeks; 189 truck drivers registered for that course and we had an average of over 135 in attendance, on their own time, of their own free wills.

We can develop a greater skill in the professional driver, a greater awareness of a problem. We send out notices this time of year to all of them in our area. It helps to remind them to be a little more careful.

CHAIRMAN: Children wouldn't be killed and children wouldn't be injured if we didn't have adults responsible primarily for their death and injuries. The prime problem here is the driver attitude.

It is too easy to get a license in this state and in every other state. You do not know enough about driving attitudes so that you treat your job as a driver the way you should. That is illustrated by the little boy who was out riding with his mother one day. He asked his mother, "Where are those darn fools that are on the highway?" She said, "Son, they are only out here when your dad is driving."

If we change the attitudes of all drivers so that they are a little more thoughtful to their neighbors we wouldn't have so many accidents.

I can point out a dozen streets in this city that we could establish as play streets to keep the children off certain places where they are getting injured; to allow them to ride their bicycles. We could do here what they do in New York, put a large sign up, "Play Street" and prohibit automobiles from using those streets between the hours of 9 and 5 in the summer time. Do we do it? No, we don't.

We have a school bus law in this state that is practically unenforceable. And that is when you see a school bus, whether you are coming from the opposite direction or going in the same direction, you must stop. Not three per cent of the population even knows the law much less obeys it. Let us go a little further, spend a few more dollars, make the school bus driver turn his vehicle around and let the child off on the side of the road that he is going to go on. We don't do that. We kill them because the school bus law doesn't make sense. Let's change the school bus law.

Now, those are just a few of the things that you folks should take into consideration as a group and as a unit. I am certain you will find that when you are through you have done more to protect your children and mine than anything the law has done so far today or any enforcement body has been able to do at this time.

HEALTH OF WOMEN IN INDUSTRY

PANEL: Chairman: Honorable Harry C. Harper, Commissioner of Labor, State of New Jersey; Miss Agnes Anderson, Industrial Nursing Consultant, State of New Jersey; Dr. Norman M. Scott, Medical Director, Medical-Surgical Plan of New Jersey; Mr. Warren Bayne, Personnel Director, E. I. duPont de Nemours Co., Inc.; Dr. Augustus Gibson, Asst. Medical Director, Merck & Co.; Miss Evelyn Dubrow, Educational Director, New Jersey State Council, CIO, and Dr. John F. Johnson, formerly of General Motors.

CHAIRMAN HARPER: The labor laws of New Jersey, among other provisions, lay down definite regulations relating to safety, ventilation and sanitation in the factories and workshops of the state, safeguarding machinery, fire alarms, work areas to be properly lighted and ventilated, separate toilets for each sex, suitable dressing and wash rooms and restrictions against garbage.

We have regulations pertaining to the hours of work and other conditions relating to the employment of women. No woman may work more than ten hours a day,

Last year we had a bill introduced into the legislature, for a 48-hour week, but it failed to pass. New York has such legislation; Pennsylvania has it, and here we are between those two states.

DR. GIBSON: Forty-eight hours is long enough for either man or woman, but women often have other responsibilities and have to have time to do shopping and take care of children, in addition to working in a factory.

MISS DUBROW: We have discovered in the long run in a general research we have done on the health of women in industry, that if they are taxed too greatly their productivity falls down.

CHAIRMAN HARPER: Next is weight lifting. Should there be a law on that? Do you think the Woman's Auxiliary could work out some kind of recommendation endorsing regulations on what women are required to handle in regard to weights and different other things and submit them to me so I could forward them to the legislature?

DR. JOHNSON: There are women who must work and who should have access to a job which pays fairly well, and the amount of work done roughly is rewarded by a higher rate of pay, as a result.

MISS DUBROW: We don't want to legislate women out of a chance to get a job.

DR. SCOTT: What you are trying to prevent there is the employment of women for hard, manual labor. It doesn't seem to me that weight lifting is a criterion for hard labor.

Would it be possible to say women should not engage in hard, manual labor as defined by the Commissioner of Labor?

Chairman Harper: It would be a good idea if The Medical Society, or the Health Department, would have a committee formed to draft a set of rules to submit to us and see if we can't do it without a law if we have to because we have done so much good by just the old American way of talking to industry.

Dr. Gibson: In preparation for this, I looked up our absenteeism records a little bit and compared those of men and women. For women, absenteeism is usually higher than for men, anywhere from five to ten times higher. About ten per cent of the absenteeism was due to causes which might be considered peculiar to women such as gynecologic conditions. Therefore, it was apparent that the high rate of absenteeism was not primarily due to diseases peculiar to women but to such other factors as women often needing to take a day off to do things at home.

A woman should have an adequate period for recuperation following childbirth, and it is better for her and for the child to be kept home longer than most of the suggestions provide.

Dr. Johnson: I would encourage a physical examination during the pre-employment interview. That physical examination can lead to a functional classification of that person. Thus, New York published a classification of four types of people; those who could do unrestricted work, those who could do any and all types of work except heavy lifting, those who were limited to a certain type of job because of physical condition, and those that were not physically able to work at the present time.

Chairman: This is a hard thing to put through with labor on seniority rights.

Miss Dubrow: The problem of seniority would not occur if you tried to match the person to the job. It would be a matter of seeing that the person with the qualifications was physically and mentally adaptable.

It is terribly important to make sure the surroundings are all right. In a great many places in New Jersey we allow women in dusty, dirty plants where they can pick up a lot of diseases, where ventilation is bad and they are subject to the common cold simply because we don't think those little things taken one by one are important.

Women in industry appreciate more than anything, plants physically equipped for their comfort and adequately sanitary.

Dr. Scott: When we started the voluntary plan movement, most of the projects followed the custom of the lay insurance companies by charging additional subscription rate in plants with predominantly female personnel. They anticipated a higher incidence of use of the contract. That has not proved to be true.

In our work, we have a relatively small plan, 120,000 people in it, but our incidence of hospitalization or utilization of our contract among single women has been at the rate of 65 per thousand per year, and for single men it is 90. That reflects a good condition of health among women in industry.

On the overall picture of women in industry, it looks to me that they are a healthier group than the men. Perhaps a woman doesn't go into industry unless she is healthy. She has other means of support, whereas a man has to work whether he has a physical defect or not, if he has dependents.

Miss Anderson: It has been estimated that eventually there will be one gainfully employed female for every three gainfully employed males sixteen years of age or over. The 1940 census showed approximately 78 per cent of the women gainfully employed to be below 45 years of age; and 32 per cent of these were married and living with their husbands.

Dr. Scott: That is 32 to 78; it does indicate in all these plans the basic health of women in industry is much better than we expected. Their physical condition is apparently at a higher level than the average employed male.

I think it is because a man with a physical defect still works, whereas a woman doesn't.

Miss Anderson: Many factors make it impossible to draw any conclusions from the data now available concerning the effect of industrial work on pregnancy and infant mortality. We must consider the type of work and the substances handled which may affect the health of the pregnant woman or the infant. There are certain exposures encountered in industrial work which may be especially hazardous to pregnant women; chief among these are exposures to certain chemical substances. Because pregnancy places an additional burden on the organs of the body as a result of both the metabolic alterations and the mechanical pressure, it would seem that any chemical substance which is capable of producing a harmful effect on the internal systems of the body, if absorbed in sufficient concentration, might be of greater danger to pregnant women than to normal women. This would certainly apply to substances which produce damage to the liver and kidneys, or produce anemias. Also, there are certain substances which, when absorbed during pregnancy, may have a specific effect on the uterus or fetus. Lead seems to be the most impor-

tant of these. When sufficient quantities are absorbed, this metal may lead to abortion or stillbirth, even fetal death; in some instances excessive exposure preceding pregnancy has caused miscarriages. Chloroform, phosphorus, mercury, carbon monoxide, etc., may pass through the placenta and exert a harmful effect on the fetus. After birth, the breast-fed infant may be subjected to the hazards of intoxication from materials secreted in the maternal milk.

Radiant energy in excess may exert an effect on pregnancy and lead to abortions. This may also exert a destructive effect on the ovaries. There are absolutely no data to support the claim that exposure to welding arcs can cause sterility.

On the whole, it would seem that industrial work and trauma have been claimed very infrequently as a cause of abortion under the compensation laws, and it seems that the danger of traumatic abortions resulting from industrial work is slight.

Many of the aforementioned factors can be handled by sound policies regarding the employment of pregnant women.

When women are encouraged to report their pregnancies and are assured of continued employment, if their health permits, they can be placed on operations free from harmful conditions if their regular work is not suitable. One can readily see the many benefits from such a policy.

Disturbances of menstruation have been attributed to exposure to lead, nitrobenzene, benzol and other chemical substances. This is still highly controversial. Fluorescent lighting was rumored to have some harmful effects on menstruation. There is no evidence to support this since there is little or no harmful radiant energy emitted from these lamps. Dysmenorrhea is greater among sedentary workers and less among those doing active muscular work.

The effects of the menstrual cycle on the ability of women to perform mental and physical work has been discussed for many years. The more recent experiments indicate that menstruation does not have any significant effect.

DR. GIBSON: On the subject of dysmenorrhea, we made a study in our plant and 75 per cent of the absenteeism could be attributed to it in 15 per cent of the women. The great majority of the women didn't have such trouble, but a few stayed away so consistently, they made the figures bad. The women working in the factory doing physical labor had less absenteeism from that cause than the stenographers.

MR. BAYNE: The du Pont Company always gives a pre-employment examination. We follow that up annually. That keeps us pretty well informed of our personnel, and we know whether people are in good health or not. As to safety, we have a very rigid checkup. First, we would not ask anybody to do anything he doesn't in his own mind think he could do. We say we would rather get another person or two more persons before you attempt lifting anything that is going to hurt your health. That policy helps a good deal toward keeping people from getting hernias or suffering other physical harm. We have job analyses and measures of efficiency dexterity, which tell us how much a man can lift or a woman can lift, and how much he can do, we use a code system. We code A, B, C and D. We can transfer an A to any job, B to not so many, C to less, and D to even less.

CHAIRMAN HARPER: I find that here in New Jersey, it is the women's group like yourselves that go out and keep plugging at it until a better law is written or a better inspection is made, because you are the mothers and the future mothers of those working in those factories. Future mothers are working in our institutions and the future mothers we must protect because they are going to be the mothers of the next generations of America; healthy mothers mean healthy children, and with a healthy next generation, America can remain in the leadership of the world.

STUDENT NURSE ENROLLMENT

PANEL: Chairman: Miss Margaret T. Corwin, Dean of The New Jersey College for Women; Miss Wilhelmine A. H. Twidale, president, New Jersey Nurses Association; Miss Grace Anderson, president, New Jersey State Organization of Public Health Nurses; Miss Wilkie Hughes, executive secretary, New Jersey Nurses Association; Mr. F. Stanley Howe, Director, Orange Memorial Hospital; Mr. George H. Buck, president, New Jersey Hospital Association; Dr. A. Charles Zehnder, chairman, Nursing Committee, The Medical Society of New Jersey, and Miss Florence E. Halderman, Directress of Nurses, Cooper Hospital.

MISS TWIDALE: In the past, nurse recruitment was done more or less by the individual schools. The war brought a change with group recruitment through the Cadet Nurse Corps. Last spring, the American Hospital Association initiated a concentrated recruitment program.

MR. BUCK: The American Hospital Association's program on nurse recruitment, planned on a national level, consists largely of sending out suggested programs for newspapers, news releases and radio activity. They have re-

leased prepared programs that can be used both on the radio and in actual audiences such as high schools and other interested groups. It must, however, be implemented on a community level.

Right now we are getting a committee organized, consisting of representatives from the State Nurses' Association and the State Hospital Association. Industry on a state level and individual commercial concerns on a local level will lend their financial support to advertising.

Mr. Buck: Another obstacle we ran up against in our own program was that high school students had their careers planned out for them by their vocational advisers even back as far as their sophomore year. When we got in to talk to the seniors their program was all taken care of. What we must do is to get the cooperation of student advisers in our high schools to carry into their work a really effective instructional program for nursing.

Miss Twidale: I feel that these three are the total picture of community service: the collegiate, the college trained or educated nurse for the higher brackets, and for supervision of teaching: the three-year basic graduate, registered nurse, the professional nurse for the skilled bedside nursing of the community; and finally the practical nurse, a graduate of a shorter course, to carry the sub-acute and chronically ill of our community.

Mr. Buck: The utilization of beds has increased about ten per cent, but it is the allied uses of nurses, industrial nursing, public health nursing and school nursing, that has drained out of the hospitals many of the nurses.

Dr. Zehnder: I am convinced that this is due to the fact that much of the work that a nurse is required to do is menial.

Miss Hughes: It might be that the courses for nurses really plan work on a professional level, yet when the girls finish they do these menial tasks. This may account for their not wanting to take up nursing.

Mr. Buck: In order to fill that need, we simply must have practical nurses and it is high time, I think, that we really put pressure on the developing of that particular program.

Mr. Howe: Industry finds they can lower their accident insurance rates enough to pay. They can have as many as they want; work eight hours; many don't work nights. Everybody today is looking for a better life, and that doesn't necessarily mean more money.

Dr. Zehnder: Industry can get all the nurses and hospitals can't because plants have social security. Nurses also have vacations, and pensions coming to them in the large industries, all that is lacking in the hospital.

Miss Krauter (Director, Essex County Girls Vocational School, Newark): I believe that we can train a number of good practical nurses if we can do the right kind of recruiting.

Miss Corwin: Are there many places they can get that training in this state?

Miss Krauter: It would be possible in New Jersey under the Vocational Division in the State Department of Education to establish practical nurses' training in a number of units. And in our vocational centers, they can do extension work for practical nursing.

Mr. Howe: Have any of you thought to remind the girls that is the only profession in the world where they can get an education practically for nothing, and as soon as they are graduated they can get full wages?

Mr. Buck: The hospital job is the one type of employment in the country today that provides the objective of all unions, and that is a guaranteed annual income.

Dr. Zehnder: Some years ago, nurses were paid to take the course. Now they have to pay to take the course.

Miss Anderson: They should be paid for the work they do that is not inherent in their education, especially during summer vacations.

Spectator: Doesn't the fact that she so often lacks home life entirely in an institutional position have something to do with the average nurse not being contented and happy?

Mr. Buck: I would like to see hospitals get rid of their nurses' homes. I would like to see nurses live as normal people in their own homes, and thus get away from this institutional environment.

Miss Haldeman: We need a state-wide organization, a committee for enrollment of students. And I think that our nursing councils very definitely should have lay participation.

Dean Corwin: The demands, the cases, the positions for women in nursing have been multiplying so fast in recent years that it has been expanding much faster that the supply. So that I think you can sense that there is a very important field for women, that many more should be encouraged to go into it, bearing in mind the three levels. Encourage young girls to apply early in their high school period at the level they are likely to make the finest contribution and correspondingly have the greatest satisfaction in their contribution to a very fine profession.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **August, 1947** **No. 8**

HOSPITAL surveys now under way will almost certainly result in greatly increased hospital facilities everywhere in the U. S. within the next decade. It would be unfortunate if in the enthusiasm for building bigger and better hospitals, the problems of those already in existence should be shelved even temporarily. Tuberculosis, whether recognized or not, is present in all mental hospitals. It can be controlled if the cases are discovered, segregated and treated.

TUBERCULOSIS IN MENTAL SCHOOLS AND HOSPITALS IN OHIO

A report of the extent of the tuberculosis problem in the mental schools and hospitals in Ohio reveals the existence of a reservoir of tuberculosis which constitutes a serious public health problem. This source of infection has not received the attention it demands.

The Ohio Department of Public Welfare, which is responsible for the care of patients of state institutions, has long been interested in determining the prevalence of tuberculosis in the mental schools and hospitals of the state to be used as the basis for the development of an adequate control program. The potential hazards of institutional life to the physical welfare of both patients and employees were recognized. However, it was realized that only through a mass survey would it be possible to ascertain the precise nature of the hazard and thereby provide the fundamental knowledge upon which to build this future program of tuberculosis control.

The present investigation embraced the total population of twelve of the fourteen mental schools and hospitals in the state. In order to obtain a basis for study of the tuberculosis problem in these institutions a review of the deaths occurring in the fourteen state institutions during the five-year period ending December 31, 1945, was made. During this period 1,094 or 13 per cent of all the deaths were due to tuberculosis. In 1943, there were 128 known cases in these institutions, in 1944 this had risen to 148 known cases. In 1945, shortly after the start of the survey, 351 cases were known or 1.55 per tuberculosis death.

The total number of individuals examined was 25,351 of whom 22,387 were patients and 2,964 were employees. X-ray evidence of tuberculosis (non-calcified primary, reinfection-type tuberculosis, pleurisy with effusion or silicosis with infection) was found in 1,474 or six per cent of the total. Another two per cent of the total screened revealed evidence of non-tuberculous lung pathology.

Of the 1,474 cases of tuberculosis, 1,379 or 94 per cent were patients and 95 or six per cent were employees. Distribution of tuberculosis by stages of disease was discovered among the resident patients and employees in approximately the same relation in which it has been found in surveys of general population groups.

Distribution of tuberculosis by age groups revealed a striking similarity between the occurrence of the disease in the patients and the employees—71 per cent of both groups were in the age groups over 45 years. The gradual increase in the percentage of cases discovered as the age groups advance suggests that prolonged residence in the institution may be an important factor in producing new cases.

The findings in this survey have served to accentuate the need for an adequate tuberculosis control program for the mental institutions in the state of Ohio. Six per cent of all the patients and three per cent of the employees were tuberculous. These rates together with the findings of a greater percentage of tuberculosis in the older residents suggests that a large part of the affected groups contract their infection during their residence in the institution.

Because of the prolonged intimate association which is a part of institutional segregation, exposure from unknown and non-isolated infectious cases must occur. Tuberculosis among employees merits the serious consideration of hospital authorities. Whatever and wherever the source of an employee's tuberculous infection, it can hardly be denied that harmful exposure to unrecognized cases occurs in many institutions. Through release of unknown communicable cases or through probationary visits or by discharge, the exposure of the general population to the disease becomes a problem of first importance. Protection of the physical health of the patient, mentally normal or psychotic, is a fundamental responsibility, yet this pool of infection has been allowed to increase abundantly. It can only be dried up through systematic surveys applied in this direction.

Fundamentally the problem stems from the commitment of individuals with infectious tuberculosis and the development of new cases while these individuals are in residence. Cases can be detected on entrance to the institution through routine screening X-rays of all admissions and preplacement X-rays of employees. Suspicious cases should be properly confirmed by the appropriate clinical and laboratory procedures which comprise an adequate diagnostic whole. Cases that develop during residence in the institution can be found through periodic routine screening of the entire institutional personnel. Active, infectious cases found on admission or during periodic check-ups should be isolated in hospital facilities especially provided for this purpose. A large percentage of suspect cases will need further observation in order to determine the activity and infectiousness of the disease. Such persons should be isolated in a separate tuberculosis unit, where further diagnostic studies can be made and their exact status established. When these cases no longer constitute a public health problem, they may be returned to their respective institutions.

Treatment of the mentally ill patient with tuberculosis is essentially the same as that prescribed for the mentally normal tuberculous patient. Rest is the basic therapeutic measure and should be obtained, if necessary, by administration of sedatives. Sputum conversion is one of the objectives of treatment and collapse therapy, as indicated, can and should be utilized to achieve this goal.

Tuberculosis in Mental Schools and Hospitals in Ohio, Mark W. Garry, M.D., Ohio Public Health, September, 1946.

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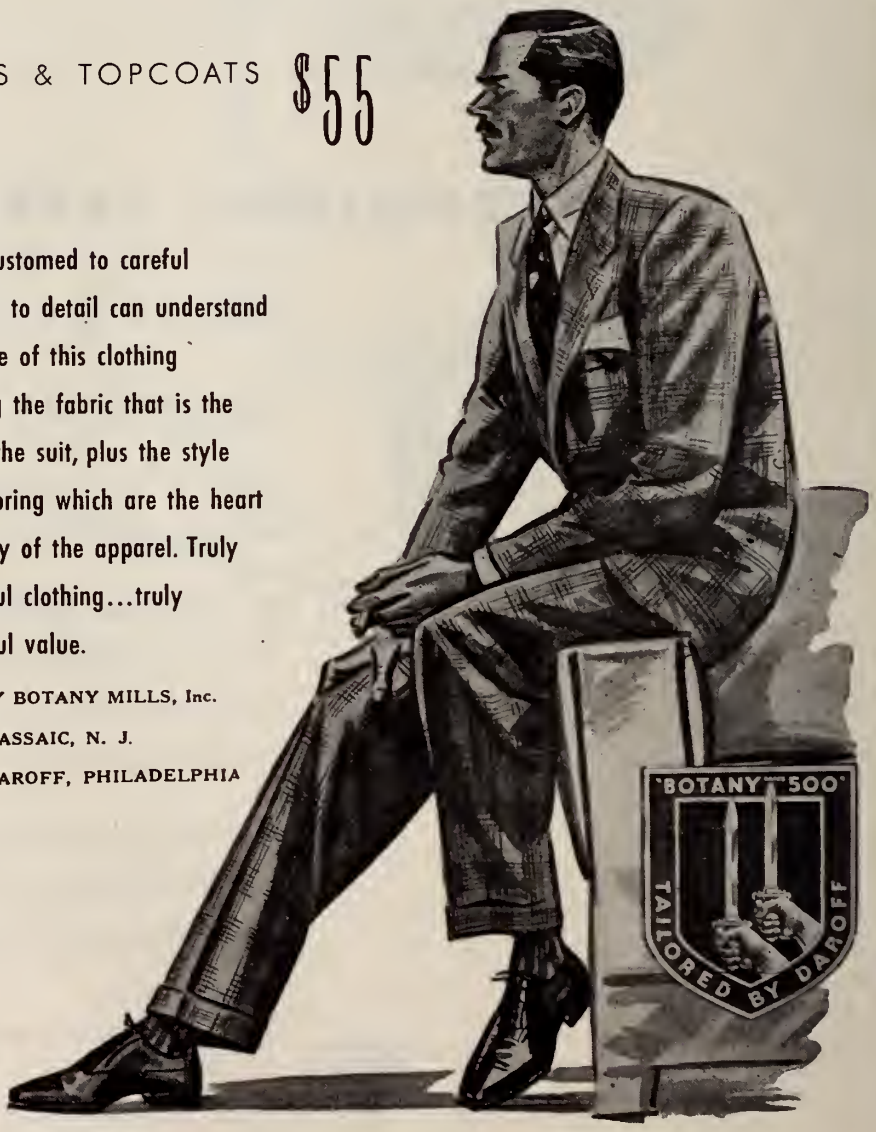
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*"Allergy in Practice," Feinberg, S. M., Second Edition: 1946, Year Book Publishers, Chicago



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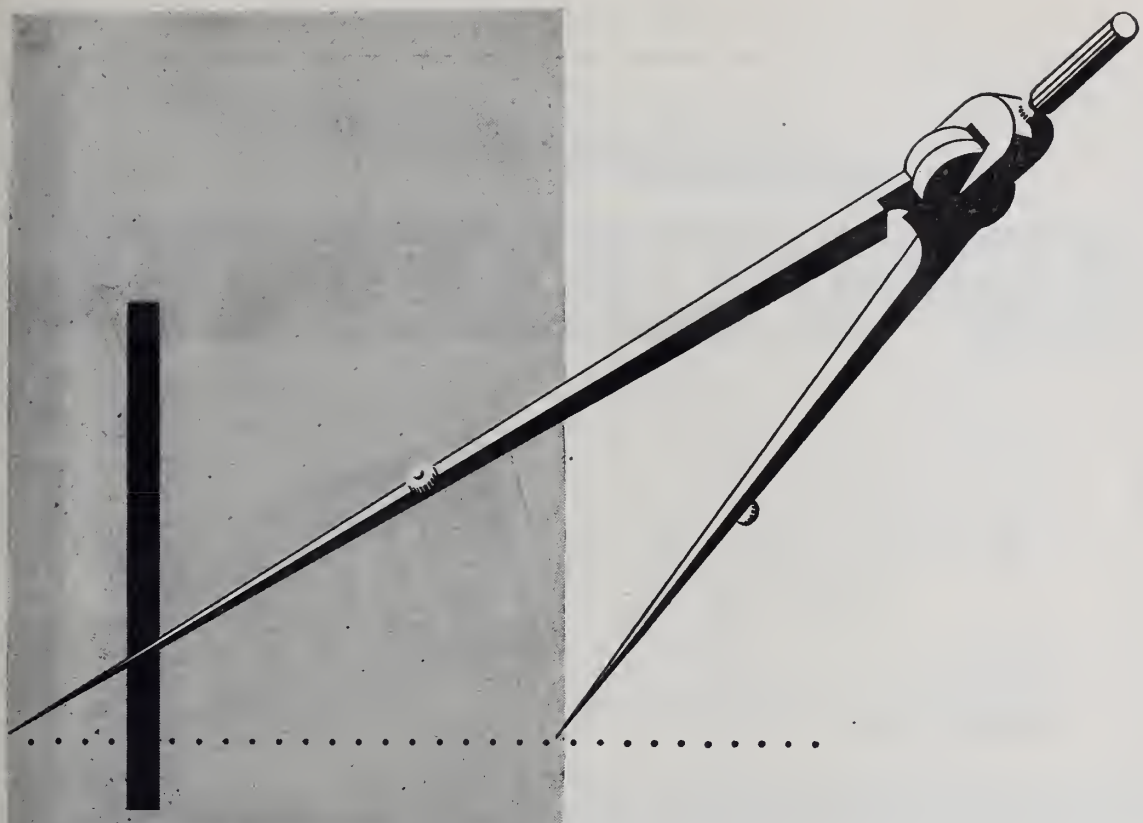
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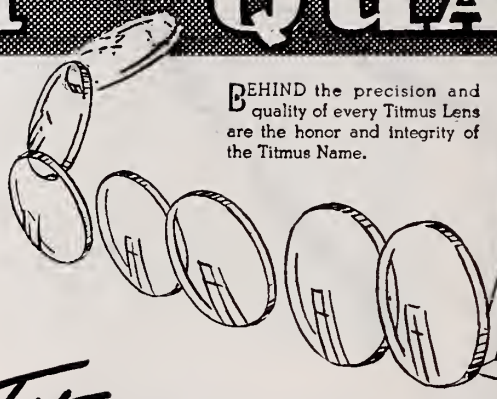
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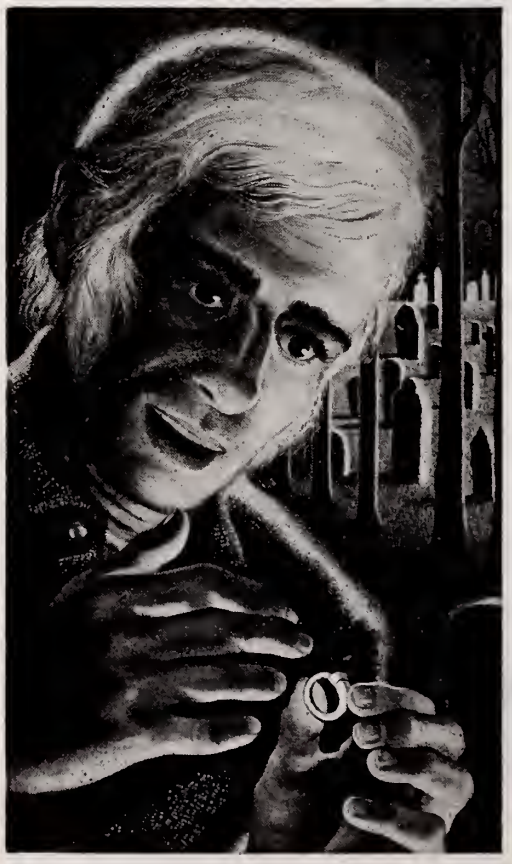
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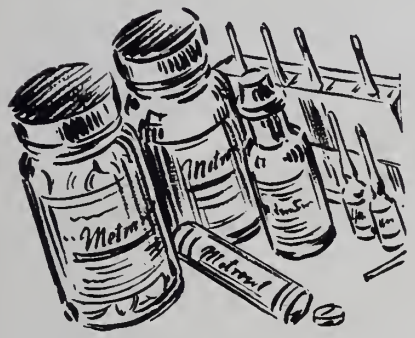
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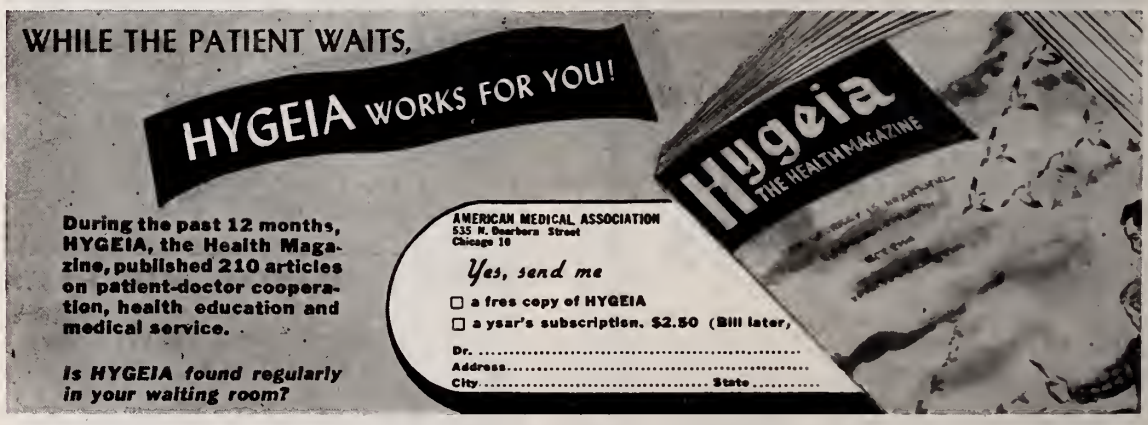
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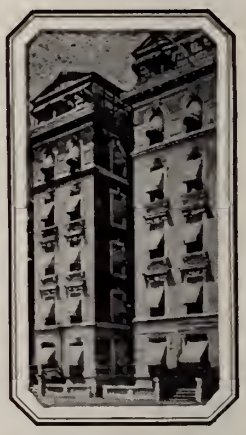
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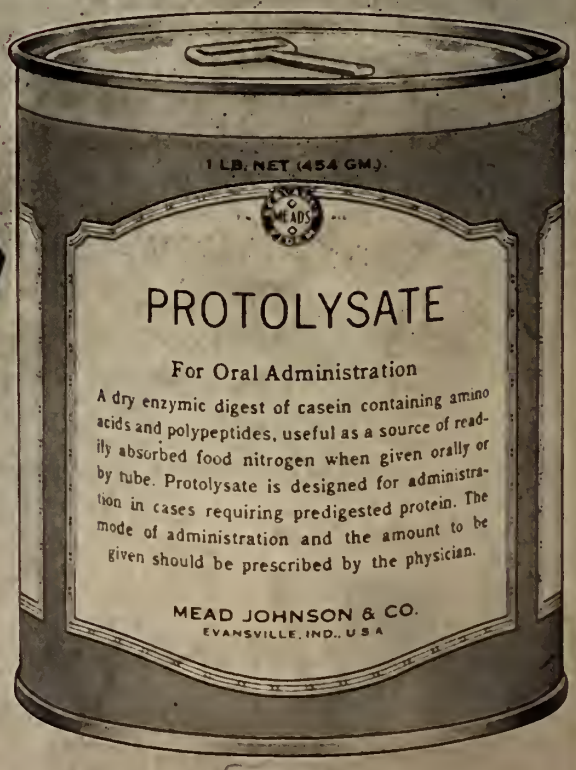
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THE 181st ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

Haddon Hall, Atlantic City, New Jersey, April 22, 23 and 24, 1947

THE OFFICIAL TRANSACTIONS

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Issued as a Supplement to The Journal of The Medical Society of New Jersey, August, 1947

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MINUTES OF THE HOUSE OF DELEGATES

Tuesday Morning Session—April 22, 1947

The first session of the House of Delegates at the 181st Annual Meeting of The Medical Society of New Jersey, held at Haddon Hall, Atlantic City, New Jersey, convened at eleven-ten o'clock, Dr. Frank G. Scammell, President of the Society, presiding.

PRESIDENT SCAMMELL: My dear colleagues. the Medical Society welcomes your return to Atlantic City in its 181st Annual Meeting. I thank you for being so kind to me during the year. You have given me the excellent support of the Society through my right-hand man, Dr. Schaaf. I don't know where the Medical Society would have been if it had rested on my shoulders. I want to thank you very much for being so kind to me and not criticizing my ascendancy to the president's chair. I want at this time to thank Dr. Schaaf publicly and before you for all his kindnesses to me, and I wish also to thank the heads of the committees.

At this time, because I am not thoroughly conversant with the conditions which have been going on in the past year (and even if I were, I don't believe I could conduct it as well as he can), I think it would be better if I turned your meeting over to Dr. Schaaf.

[Dr. Royal A. Schaaf, Newark, N. J., Acting President, took the chair.]

ACTING PRESIDENT SCHAAF: Thank you Dr. Scammell.

We will proceed to the organization of the House of Delegates, and I will call on the Chairman of the Board of Trustees for the credentials report.

DR. ALDRICH C. CROWE (Ocean City, N. J.): Dr. Schaaf, all the delegates are properly certified.

ACTING PRESIDENT SCHAAF: Thank you, Dr. Crowe.

We will announce the Reference Committees.

The Chairman of Reference Committee "A" is Dr. Ulmer.

I would like to note at this time that we regret the loss of Dr. Brennock of Jersey City, who, as you know, was to have been Chairman of Reference Committee "B". Dr. Herschel S. Murphy has been appointed to replace Dr. Brennock, and Dr. Butler has been named as the new member of Reference Committee "B".

The Chairman of Reference Committee "C" is Dr. Sigurd W. Johnsen.

The Chairman of Reference Committee "D" is Dr. David B. Allman, of Atlantic City.

The Chairman of Reference Committee "E" is Dr. Henry C. Barkhorn.

The Chairman of the Reference Committee on Constitution and By-Laws is Dr. Edward W. Sprague.

The Chairman of the Reference Committee on Miscellaneous Business, to consider also the reports of the Annual Meeting Committee, and so forth, is Dr. David W. Green, of Salem County.

The Chairman of the Reference Committee on Resolutions and Memorials, and to consider the report of the Committee on Honorary Membership, is Dr. Samuel A. Cosgrove, of Hudson County.

The Chairman of the Reference Committee on Credentials is Dr. Aldrich C. Crowe.

I would like to call attention to an error in the published list of District Councilors. On page 2 of your program you will note that the Councilor for the First District, which includes Union, Warren, Morris and Essex Counties, is listed as Dr. J. Wallace Hurff, whose term expired in 1947. Actually, our Judicial Councilor for the First District is Dr. Francis C. Weber of Newark. Dr. Hurff was the delegate to the American Medical Association from the First District. Please make that correction. We apologize to Dr. Weber for the lack of consideration which we unconsciously and unintentionally showed him.

The next order of business is approval of the TRANSACTIONS at the last convention of the House of Delegates, held in May 1946, and published as a supplement to the August 1946 JOURNAL. The Chair will entertain a motion to approve the minutes as published in this supplemental publication.

DR. DAVID B. ALLMAN (Atlantic City): I so move.

DR. HERSCHEL S. MURPHY (Roselle): I second the motion.

(The question was called for, and the motion was put to a vote and carried.)

We will now call for the annual and supplemental reports of committees.

The report of the Treasurer was published on page 138 of the April JOURNAL and will be referred to Reference Committee "B". I will ask Dr. Young to present a supplemental report at this time. Dr. Young.

DR. GEORGE J. YOUNG (Treasurer, Morristown): Since the fiscal year does not close until May 31, we submit an interim report from June 1, 1946, up to April 15 of this year.

Our receipts, which were the assessments from the twenty-one counties, a small amount of interest, income from the sale of maternal welfare books, rental of an apartment in our permanent home, a little unexpected revenue, receipts from commercial exhibits, receipts from JOURNAL advertising, and a small amount from the Scientific Research Fund which was disbanded the early part of this fiscal year, amounted to $140,874. Added to the balance as of June 30, 1946, which was $71,489, this gives us net receipts of $212,363.

Balance, June 1, 1946	$ 71,489.10

RECEIPTS
June 1, 1946 - April 15, 1947

Assessments:		
Atlantic County	$ 3,225.00	
Bergen County	7,885.00	
Burlington County	1,825.00	
Camden County	5,895.00	
Cape May County	890.00	
Cumberland County	1,525.00	
Essex County	31,295.00	
Gloucester County	1,075.00	
Hudson County	13,160.00	
Hunterdon County	695.00	
Mercer County	6,125.00	
Middlesex County	4,420.00	
Monmouth County	3,875.00	
Morris County	3,620.00	
Ocean County	750.00	
Passaic County	10,320.00	
Salem County	600.00	
Somerset County	1,625.00	
Sussex County	800.00	
Union County	10,625.00	
Warren County	775.00	
		$111,005.00
Interest (net)		125.78
Sale of Maternal Welfare Books		140.00
Permanent Home (rent-net)		359.30
Revenue Unexpected		8.61
Commercial Exhibits (net)		7,914.50
Journal Advertising (net)		21,230.01
Scientific Research Fund (net)		91.46
Net Receipts		$212,363.76

Our disbursements, which were divided among thirty-two budgetary items all the way from payment of salaries down to the payment of a pension to one of our former secretaries, Dr. Morrison, amounted to $74,427.

BUDGET ACCOUNTS
(June 1, 1946 - April 15, 1947)

BUDGET ACCOUNTS:	
A- 1—Acting Executive Officer, Salary	$ 833.33
A- 2—Executive Office Salaries	8,009.44
A- 3—Executive Office Expenses	971.37
A- 4—Executive Office Travel	412.25
A- 5—Permanent Home Operating Exp.	4,961.75
A- 6—Treasurer	64.61
A- 7—Finance and Budget Committee	.....
A- 8—Bonding	77.50
A- 9—Audit	327.40
A-10—Secretary	845.86
A-11—Salary Taxes	379.19
A-12—Insurance	393.84
B- 1—Journal Publication	16,876.88
B- 2—Journal Cuts	10.60
B- 3—Editor's Salary	2,083.33
B- 4—Editorial Office Salaries	2,480.67
B- 5—Editorial Office Expenses	323.21
B- 6—Journal Travel	24.00
C- 2—Welfare Committee	545.82
C- 3—Legislative Committee	5,189.54
C- 4—Public Health Committee	262.27
C- 5—Public Relations Committee	4,074.27
C- 6—Medical Practice Committee	75.80
D- 1—President	698.79
D- 2—A. M. A. Delegates	2,573.26
D- 3—Conference Dues	50.00
D- 8—Woman's Auxiliary	1,600.00
D-11—Medical Service Administration	11,483.33
D-13—Post-Graduate Education Com	.....
D-15—Veterans Liaison Committee	2,569.96
E —Contingent	2,386.85
H —Pension	1,250.00
	$ 71,835.12
1945-46 Accounts Payable	2,352.18
Remission of 1946 Dues	240.00
Net Disbursements	$ 74,427.30
Cash Balance, April 15, 1947	137,936.46
	$212,363.76

PERMANENT CAPITAL FUND

	May 31, 1946	Apr. 15, 1947
Cash	$ 2,634.06	$ 3,227.03
U. S. Savings Bonds	10,500.00	11,500.00
U. S. Treasury Bonds	1,022.97	.....
Investors Mortgage and Realty	468.25	.....
Trenton Mortgage Service Company	439.97	439.97
	$15,065.25	$15,167.00

KIPP MEMORIAL FUND
Eye, Ear, and Throat Section

	May 31, 1946	Apr. 15, 1947
Howard Savings Institution, Cash	$ 39.26	$ 39.62

Since our receipts were $140,874 and our disbursements amounted to $74,427, really our profit for the past year amounted to $66,447. This, added to the $71,489 that we had on hand as of June 30, 1946, gives us a cash balance as of April 15 of this year of $137,936.

ACTING PRESIDENT SCHAAF: Thank you, Dr. Young. This supplemental report will be referred to Reference Committee "B", along with the original report.

I would like to ask the Secretary if there is a quorum present.

DR. ALFRED STAHL (Secretary, Newark): There is.

ACTING PRESIDENT SCHAAF: We will now call for the supplemental report of the Finance and Budget Committee by Dr. Allman. The original report was published on page 139 of the April JOURNAL.

DR. DAVID B. ALLMAN (Atlantic City): Your Finance and Budget Committee has computed the salaries and has received requests from the various committees for the amounts that they will need during the ensuing year. It is estimated at this time that the total budget for all the Society's activities will be $82,770. We respectfully request that amount, Mr. Chairman, for the budget.

BUDGET—1947-48

ADMINISTRATIVE AND EXECUTIVE:		
A- 1—Salaries—Executive		$14,000.00
A- 2—Salaries and Wages — Executive Staff		12,800.00
A- 3—Office Expenses		1,200.00
A- 4—Travel		1,200.00
A- 5—Permanent Home — Operating Expenses	$ 6,000.00	
Library	500.00	
		6,500.00
A- 6—Treasurer		8,200.00
A- 7—Finance and Budget Committee		100.00
A- 8—Bonding		80.00
A- 9—Audit		330.00
A-10—Secretary		2,000.00
A-11—Salary Taxes		650.00
A-12—Insurance		400.00
JOURNAL: Estimated Receipts	$31,600.00	
B- 1—Publication	$22,000.00	
B- 2—Cuts	100.00	
B- 3—Editor's Salary	1,200.00	
B- 4—Salary and Wages—Staff	5,100.00	
B- 5—Office Expenses	500.00	
B- 6—Travel	200.00	
B- 7—Commission	2,500.00	
	$31,600.00	
WELFARE:		
C- 1—Welfare Committee		800.00
C- 2—Legislative Committee		7,000.00
C- 4—Public Health Committee	$1,000.00	
Public Health Week	1,500.00	
		2,500.00
C- 5—Public Relations Committee	$4,000.00	
Health Congress	1,000.00	
		5,000.00
C- 6—Medical Practice Committee		600.00
SPECIAL:		
D- 1—President		2,000.00
D- 2—A.M.A. Delegates		1,100.00
D- 3—Conference Dues		100.00
D- 5—Fall Clinical Conference		1,000.00
D- 8—Woman's Auxiliary		2,300.00
D-11—Medical Service Administration		4,160.00
D-13—Post-Graduate Education Committee		250.00
D-15—Veterans Liaison Committee		3,000.00
E —Contingent		3,000.00
F —Legal		1,000.00
G —Annual Meeting — Estimated Receipts	$7,500.00	
1948 Annual Meeting	7,500.00	
H —Pension		1,500.00
TOTAL BUDGET, 1947-48		$82,770.00

On a per capita basis, this figures out to just a few cents short of $20, and we therefore recommend that the annual assessment for the ensuing year be $20.

ACTING PRESIDENT SCHAAF: Thank you, Dr. Allman. The report of the Finance and Budget Committee will be referred to Reference Committee "B".

We will call for the supplemental reports. The report of Dr. Scammell was published on page 136 of the April JOURNAL, and he has no supplemental report. Dr. Scammell's report will be referred to Reference Committee "A".

There is a supplemental report from the Board of Trustees. I will ask Dr. Crowe to present it at this time.

SUPPLEMENTAL REPORT
Aldrich C. Crowe, M.D., Chairman

The Board of Trustees met last night and the following supplementary report is offered for your consideration:

1. (a) Resolved: The Medical Society of New Jersey expresses to Alfred Stahl upon the occasion of the completion of ten years in office as Secretary, its appreciation and gratitude for his loyal service. During this long tenure in office, which included the difficult war years, he served the Society faithfully and with distinction.

Be it further resolved that this expression of gratitude be recorded and published in the TRANSACTIONS.

(b) That the Society present to Dr. Stahl, in recognition of his years of service as Secretary, a Society Key engraved—"Secretary 1937-1947".

2. The Board approved resuming the Fall Clinical Conference in 1947, with an Elias J. Marsh lecture being held on the closing night.
3. The Board approved a recommendation that all veteran medical officers who were members in good standing of The Medical Society of New Jersey at the time of entrance into military service shall be entitled to one full year's credit or remission of dues.

ACTING PRESIDENT SCHAAF: Thank you, Dr. Crowe. The supplemental report of the Board of Trustees contains several items, and they will be assigned to the appropriate Reference Committees.

ACTING PRESIDENT SCHAAF: There is no supplemental report from the Secretary.

The reports of the Judicial Councilors—Dr. Weber, Dr. Butler, Dr. Fuhrmann, Dr. Stokes and Dr. Ulmer—have been published on page 138 of the April JOURNAL, and they have no supplemental reports. Their reports will be referred to Reference Committee "A". There is no report from the Publication Committee supplemental to the one which appeared on page 140 of the April JOURNAL, which is referred to Reference Committee "B". I now call on Dr. Londrigan to make a supplemental report for the Veterans Liaison Committee.

DR. JOSEPH F. LONDRIGAN (Hoboken): Mr. President, we have a supplemental report, and I would suggest that it be referred to the Reference Committee that has received the original report, where it will be presented this afternoon.

ACTING PRESIDENT SCHAAF: Thank you, Dr. Londrigan. The original report and its supplement will be referred to Reference Committee "C".

The report of the Board of Medical Examiners, Dr. Hallinger. Is there any supplemental report?

DR. EARL S. HALLINGER (Camden): There is no supplemental report.

ACTING PRESIDENT SCHAAF: The report of the Board of Medical Examiners, as published on page 165 of the April JOURNAL, will be referred to Reference Committee "C".

There is no supplemental report for the Post-graduate Education Committee, the original of which appears on page 141 of the April JOURNAL. This will be referred to Reference Committee "D".

The Scientific Work Committee's original report appears on page 140 of the April JOURNAL, and that will be referred to Reference Committee "D".

Medical Defense and Insurance, Dr. Hurff. Is there a supplemental report?

DR. J. WALLACE HURFF (Newark): We do have a supplemental report.

ACTING PRESIDENT SCHAAF: Is it brief or not?

DR. HURFF: No. It is lengthy.

ACTING PRESIDENT SCHAAF: Then, it may be submitted, and we will transmit it to Reference Committee "D", along with your original report.

SUPPLEMENTAL REPORT COMMITTEE ON MEDICAL DEFENSE AND INSURANCE

April 1947

Our preliminary report noted that there were approximately 3800 physicians insured under the special professional liability contract approved by the Medical Society.

Your committee has reviewed the statistical report of the insurance company relative to their claim experience. This discloses that there were 59 claims reported during the year. In comparison with other years, this is a good record, particularly when one considers the pressure under which our profession has been laboring. However, upon investigating the cause of the complaints, the major portion of these claims have been serious. The company paid losses amounting to $34,847.31, expenses on which were $4,925.02; reserves on cases still open were $52,500.00. There are in reserve on eleven prior cases $90,600.00, of which $41,500.00 represents two cases in suit.

It is the duty of the Committee to indicate periodically those trends which may jeopardize the interests of the membership as a whole. The two claims against which $41,500.00 is held in reserve were the outcome of administering spinal anesthesia. We have also been informed of a third case just reported. Your Committee prefers not to make any recommendation at the present time in this connection but would emphasize its importance from an insurance viewpoint.

As a result of conference, the insurance company has agreed to give your State Committee a 60 day notice in cases in which they desire not to renew a professional liability policy, together with complete data, upon which they have based their conclusion.

1. It will be their aim to make available to every member of our society a basic policy of professional liability insurance for ten to thirty thousand dollar limits encouraging the optional increased limits because of the known trend toward higher awards.

2. In cases where the insurance company is reluctant to renew a policy the following procedure will be adopted:

a. We will require a complete detailed report by the company disclosing their reason for refusal of renewal or rejection of an application for insurance.
b. Your Committee will then communicate with the Insurance Committee of the county society of

which the doctor is a member, with the request that they make a complete investigation and report to the State Committee. This investigation should include the following points:

1. Has he or has he not been unduly careless or negligent?
2. He has or has not followed methods of diagnosis, treatment or technic of practice used by the average physician?
3. It is most important that the doctor's reputation among his fellow practitioners be given serious consideration.
4. Any hospital records and statements made by the claimant should be verified.

3. Upon receipt of this report the doctor will be requested to meet with the Committee, at which time the report of the County Committee will be received; consider the question in all phases and make its recommendations to the Insurance Company. Stenographic records of the proceedings will be kept.

4. Applications for insurance involving special hazards such as x-ray and radium therapy, where the applicant is a diplomate of the American Board of Radiology will be sufficient qualification for acceptance of insurance.

When applicants are not recognized by the Board, the Committee will require an endorsement of three doctors, one of whom should be a diplomate.

RECOMMENDATIONS

1. That each county society maintain a Medical Defense and Insurance Committee, which should be a standing committee, the personnel of which should be appointed for a term of three to five years.

2. Renewal of the contract with U. S. Fidelity & Guaranty Company through our official broker, Faulhaber & Heard, Inc., whose offices should maintain records of all communications and transactions for the Committee.

ACCIDENT AND HEALTH

The Committee is aware that there has been demand for higher maximum indemnity. Upon request we have succeeded in having the company's monthly indemnity limit increased from $300 to $400. This indemnity will be optional for those on an insurable basis, whereas the impaired risk will be on the average within the county limitation. The National Casualty Company have also agreed to inaugurate another non-selective 30-day enrollment period. This will benefit particularly the new members and those veterans who did not have an opportunity to subscribe during the original enrollment period.

Our agency for the accident and health plan, E. & W. Blanksteen, reports that the number of members insured is now over 55 per cent of the members of the Society actively engaged in the practice of medicine. They further report the total amount paid in claims was $57,000.00 on 181 claims presented and there are 191 pending cases. During the past year one claim was arbitrated and decided in favor of the claimant and paid in full by the company in accordance with the agreement stipulated in each insurance contract.

RECOMMENDATIONS

That the President and Secretary of the Society be authorized to execute an amendment to our master agreement on accident and health with the National Casualty Company, providing for an increase of maximum monthly indemnity from $300 to $400; also providing for an additional $5,000 dismemberment indemnity in those policies carrying $300 per month indemnity for additional premium of $1.00.

That the contract with E.& W. Blanksteen agency be renewed.

We call on Dr. Dodd for a supplementary report of the Advisory Committee to the Woman's Auxiliary.

(Dr. William E. Dodd, Beach Haven, read the supplementary report of the Advisory Committee to the Woman's Auxiliary.)

SUPPLEMENTAL REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

At the request of the Woman's Auxiliary, the Advisory Committee met on March 16, 1947, and approved the following projects proposed by the Woman's Auxiliary. The Board of Trustees approved the action taken by the Advisory Committee at its regular March meeting.

1. To coordinate the activities of the Woman's Auxiliary with those of The Medical Society of New Jersey for the coming year, it is proposed that the Woman's Auxiliary hold a "Work Shop Day" at the Society's headquarters in Trenton in the spring or early summer, at which time the chairman of each subcommittee of the Welfare Committee meet with the chairman of a similar committee of the Woman's Auxiliary to which would be invited the corresponding chairman of each component county auxiliary. The purpose of this meeting would be to acquaint the Woman's Auxiliary and each of its component county units with the work of The Medical Society in the scope of each of these subcommittees; to promote discussion of mutual problems; and to aid in formulating a program of endeavor which will be of utmost benefit to the public and to The Medical Society of New Jersey.

2. It is proposed that the Woman's Auxiliary hold a round table conference at the State Headquarters in Trenton on problems of interest to the women in the field of health, to which would be invited a representative from all state organizations of women. For purposes of discussion this conference could be divided into sections. One section would be presided over by a prominent educator; another by a prominent judge; another by a public health nurse, another by a leader in the field of home safety and so on. It is proposed to hold this meeting near the time of the annual meeting of the American Medical Association in order that

prominent speakers attending the A. M. A. Convention might be secured to speak before this conference.

3. As an outgrowth of the conference just proposed, should it be successful, it is proposed that the Woman's Auxiliary hold an all day institute on health problems of interest to the women of New Jersey during Health Week this October.

W. E. DODD, M.D., Chairman,
Advisory Committee to the
Woman's Auxiliary.

ACTING PRESIDENT SCHAAF: Thank you, Dr. Dodd. The supplementary report of the Advisory Committee to the Woman's Auxiliary will be referred to Reference Committee "D", along with the original report which was published on page 141 of the April issue of the JOURNAL.

There is no supplemental report for the Welfare Committee. The original report, published on page 142 of the April JOURNAL will be referred to Reference Committee "E".

We will now call on Dr. Pollak to make a supplemental report for the Legislative Committee.

DR. BERTHOLD S. POLLAK (Jersey City): Mr. President and Gentlemen of the Society: Owing to the fact that the Legislature did not adjourn until five-thirty this morning, we are not able to give you a full report. The report that I am to read was brought here yesterday afternoon by me and was typed by the clerical staff.

(Dr. Pollak read the supplemental report of the Subcommittee on Legislation.)

SUPPLEMENTAL REPORT
SUBCOMMITTEE ON LEGISLATION

The report of this Committee, published in the April JOURNAL, dealt with federal legislation and was confined to discussion of two bills. One was Senate No. 140, the Fulbright-Taft bill to establish a Department of Health, Education and Security to be headed by a Secretary who would be a member of the Cabinet. The other measure was Senate No. 545, the Taft-Smith-Ball bill, which provides (a) for the placing of all public health and medical activities of the Federal government, except those of the Army, Navy and Veterans Administration, in a single agency—the National Health Agency, and (b) grants-in-aid to the states to establish state plans to make possible improved medical, dental and hospital care "for families and individuals with low income."

In mentioning the appropriation, (in our report as published in the JOURNAL) that would be available to the states for this purpose, it was remarked that $20,000,000 would be appropriated each year for five years. Instead of $20,000,000 yearly appropriation, the bill provides for $200,000,000.

In view of the fact that Senator H. Alexander Smith is chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, which will hold hearings on S. No. 545 and other health bills, the Director of the Bureau of Legal Medicine and Legislation of the American Medical Association has expressed the opinion, which coincides with our own, that it would be "very advisable" that our Society be represented at these hearings. A communication received from Senator Smith a few days ago, in reply to our application to him for opportunity to be heard on this measure, states that as soon as the Committee has decided on the time of the hearings, we shall be advised so that we may have a representative of our Society testify.

We understand that the representatives of the American Medical Association who will testify at these hearings will be Dr. Sensenich, Chairman of the Board of Trustees, and Dr. McCormick, Chairman of the Council on Medical Service.

At the hearing, early in March, before the Senate Committee on Expenditures in the Executive Departments, on S. 140 (the bill to create a Department of Health, Education and Security) Dr. Sensenich and Dr. James R. Miller of Connecticut testified in opposition to the bill.

While this committee has not as yet made a report on S. 140, it is conceivable that if the hearings on S. 545 are unduly postponed, action by the Senate, in the event of a favorable committee report on S. 140, might be taken before the hearings on S. 545 get under way.

In concluding this portion of our report dealing with federal legislation, we should like to repeat and underscore the observation we made in our main report: *"In our opinion it is a delusion to assume by reason of the 1946 Congressional election, that the threat of 'socialized medicine' is over."*

STATE LEGISLATION

It is not our intention to discuss here all the public health bills which we followed at this session of the state Legislature. It had been our expectation that the Legislature would have adjourned last week, and thus have made it possible to have reported fully on all major bills in which we are interested. As this report is being written two days before the date on which it is to be delivered and one day before the closing session of the Legislature, we shall have to leave some gaps which we hope to fill in by late telephonic or telegraphic advice from the Executive Secretary of the Committee, who will remain in Trenton until the session has adjourned.

This year three Assembly bills, A. 88, A. 30 and A. 444 have been the cause of considerable anxiety and unusually hard work on the part of this Committee, and of County Society Keymen. Here we would like to acknowledge gratefully the fine cooperation, speaking generally, of the County Keymen and of their Societies. We appreciated also the fine editorial in the Newark Evening *News* in opposition to A. 88 and A. 30. Both measures were designed to make possible the medical licensure of groups of graduates of unaccredited medical schools.

A. 88 (Mr. Reiffin, Passaic County) squeezed through the Assembly by just the necessary 31 votes and has been reposing since March 31 in the Judiciary Committee of the Senate.

A. 30 (Mr. Mischlich, Atlantic County) was reported out by the Ways and Means Committee March 17, but has not been moved. Our understanding is that it did not receive sufficient in caucus of the majority party.

A. 444 (Miss Doremus, Passaic County) to create a Board of Chiropractic Examiners, was introduced March 24, reported by the Judiciary Committee March 31, and came to a vote on final passage April 7, failing by four votes to receive the necessary 31 votes for passage.

A. 6—reorganizing the State Department of Health has passed both houses, but has not yet been signed by the Governor.* This measure as amended provides for the appointment by the Governor of a Commissioner of Health at an annual salary of $15,000. The Commissioner must be a licensed physician with at least five years' full time experience in an executive or administrative capacity in a department of health. The Health Council, one of whose functions is to write the Sanitary Code, is to be composed of seven members, two of whom would be physicians. It is still our opinion that the act should have provided that the majority of the members should be of the medical and allied professions. However, the Governor let it be very definitely known that if the bill was amended so as to provide for any more "designated" members he would veto it. We are satisfied that attempts this year to amend the bill in this respect would have been without avail and would have probably incurred the displeasure of a Governor, who, while a state senator had consistently supported our efforts in behalf of sound public health legislation. While the measure does not meet the wishes of the Society as to the composition of the Health Council, we are convinced that Governor Driscoll will appoint a *good* Council and a *qualified* Commissioner.

S. 103 which was sponsored by the New Jersey Health and Sanitary Association, was designed to permit the establishment of county or part-county health districts. It was the definite understanding that no attempt would be made to move this measure until A. 6 (Reorganization of the Department of Health) had passed the Legislature. The lateness of the passage of A. 6 and the resignation of the introducer of A. 103, (Senator Proctor) to become a Circuit Court Judge, were responsible in largest measure, we believe, for failure to advance this bill.

A. 474—Creates a cash sickness and disability plan for employees suffering from non-occupational sickness or disability, to be administered by the Unemployment Compensation Commission; provides for operation of voluntary plans and of a state plan.

Originally the Commission on Post-War Economic Welfare recommended the institution of *state supervised* plan. An amendment to the Social Security Act passed by the last Congress, made available to the state for cash sickness in whole or in part the amount of employee contributions paid into the Unemployment Insurance fund. (New Jersey is one of four states requiring employee contribution to the Unemployment Insurance fund). Shortly after it was made known there would be available to New Jersey at the beginning of this year over $180,000,000 in cash sickness benefits, Governor Edge requested the Commission on Post-War Economic Welfare to reexamine the subject in the light of this unexpected monetary windfall. Governor Driscoll in his inaugural address recommended the enactment of a Cash Sickness Benefits Act and requested the Commission on Post-War Economic Welfare to consider an adaptation of the California plan. Following this recommendation of the Governor the Commission presented an adaptation of the California plan which has become Assembly Bill No. 474, and which presumably will be acted upon before adjournment of the Legislature.

At the first hearing on this subject before the Commission on Post-War Economic Welfare we appeared and presented a statement: (a) endorsing the principles of cash sickness benefits to compensate partly for loss of wages due to unemployment caused by sickness or disability; (b) urging that it be made obligatory on the part of all employers to provide cash sickness benefits, preferably through the extension of voluntary cooperative plans.

In this statement we spoke at some length about the certification of illness and endeavored to impress the Commission with the concern that the medical profession had for this vital phase of any cash sickness benefit plan.

At the second hearing on this subject we supported the recommendation made by the Commission in its report delivered after study following its first hearing: (a) for full utilization and extension of voluntary plans; and (b) making it obligatory upon the part of those employers having no mutual voluntary plan to carry insurance to provide for sickness benefits. In other words, the plan recommended provided for a state *supervised* plan, not a state *operated* plan.

At the hearing before the Judiciary Committee of the Assembly, we submitted a statement in opposition to A. 474. Copies of the three statements relative to this subject will be available to the Reference Committee.

S. 50 revises the Nurses Practice Act and makes permissive the licensing of practical nurses. As amended, this measure met the approval of this Committee, the State Nurses Association, and the New Jersey Hospital Association. An amendment of significance is the requirement that the Board of Nurses Examiners, in matters concerning curricula and standards of schools of nursing, *shall* consult with The Medical Society of New Jersey and the New Jersey Hospital Association.

A sizable number of bills to amend the Workmen's Compensation Act were, as usual, introduced this year. As has been the custom, copies of bills of major importance in this category were forwarded to the Committee on Workmen's Compensation.

* The bill was signed on May 22.

As no action was recommended by this Committee to the Committee on Legislation with respect to any of these bills, no action was taken.

S. 285 sponsored by the New Jersey Dental Society, provides for the examination and licensing of dental hygienists. This measure has passed both houses.

For many years—close to thirty, if my memory serves me—there have continuously been members of the medical profession in the state Legislature. In the 1920's there were two medical men in the Senate; and until the latter part of the 1930's, one in the Senate. During that period and until recent years, there were always three or four doctors in the Assembly. This representation shrank to two, both coming from Essex, and, for the past two years to one, Dr. Hill of Newark. At the moment it appears that for the first time in thirty years there will not be a physician in the Legislature next year. This is Dr. Hill's last year. To Dr. Hill, and to all the other medical men who have served in the Legislature, this Society owes a great debt of gratitude. The knowledge that it is most unlikely that there will be a doctor in the Legislature next year, makes us realize with peculiar keenness just how much their presence has meant to us in our legislative endeavors.

Finally we desire to call attention to the fact that an ever-increasing effort is being made by sectarian practitioners and other sources to attack the principle of the Uniform Practice Act. Apropos of this we understand that a situation has arisen—due, we believe, in large measure to a misunderstanding on the part of a segment of our members about the Act of 1935 as it affected osteopaths and which was incorporated in the Uniform Medical Practice Act of 1939 with respect to licensing of osteopathic physicians and the accrediting of their schools. We are of the opinion that the present situation with respect to the crediting of osteopathic schools should be treated with caution lest we be confronted next year with legislation from this group, the objective of which would be to create a separate Board of Osteopathic Examiners.

To maintain the high standard that we have helped to have placed upon the statute books of our state, eternal vigilance on our part is most essential so that we may continue along the path chosen by The Medical Society of New Jersey to serve the public in all matters pertaining to its health and well-being.

During the past years your Committee on Legislation has been called upon by many agencies to support efforts which would permit graduates of schools (not Class A) to take the examination for licensure. You have been advised concerning these matters. Our Committee has diligently examined all facts in each case and by the most assiduous attention of Dr. Frederic J. Quigley, Executive Secretary of our Committee, and the fine cooperation of the Legislative Keymen and other members of the county societies, we have endeavored to circumvent any deviation from the laws of our state governing licensure of applicants to practice medicine in New Jersey.

Our Committee desires here to acknowledge to Dr. Quigley our appreciation of the faithful service he has so unstintingly rendered. To the members of the Committee on Legislation I personally desire to express my sincere appreciation for their cooperation and for their continued interest. Our Committee desires to express to Dr. Samuel Alexander, Trustee Adviser to our Committee, our thanks for his untiring efforts and cooperation which have been most helpful and which have been greatly appreciated by all of us.

DR. POLLAK (Concluding): These final remarks were sent to me by way of a telegram to me from Dr. Quigley, in which he advises that the Legislature adjourned at five-thirty this morning. His message is as follows:

"Legislature adjourned five-thirty this morning. A-88, A-30, and A-444 all died. No attempt to move any one. A-474 not moved. Lacked sufficient votes in caucus. And so to bed, tired but content."

This is most respectfully submitted, Mr. Chairman.

ACTING PRESIDENT SCHAAF: Thank you, Dr. Pollak. This excellent supplemental report will be referred to Reference Committee "E", along with the original report of the Subcommittee on Legislation as published on page 143 of the April JOURNAL.

I would like at this time to speak of the magnificent work which the Legislative Committee has done in the past year. We had serious threats of impairment of our Medical Practice Act by the admission of graduates from substandard schools. There was a great deal of sentiment in the Legislature, particularly in the Assembly, in favor of these bills. The Legislative Committee under the direction of Dr. Pollak, with the advice of Dr. Alexander and the actual executive work of Dr. Quigley, in cooperation with the Keymen in the counties, succeeded in defeating these bills; and the Chair would therefore entertain a motion of thanks to the Legislative Committee and particularly to Drs. Pollak, Alexander and Quigley, for their signal service to the Society during the past year.

(Such a motion was regularly seconded, put to a vote and unanimously carried.)

ACTING PRESIDENT SCHAAF: The original report of the Subcommittee on Medical Practice was published on page 146 of the April JOURNAL, and it will be referred to Reference Committee "E".

DR. WATSON B. MORRIS (Springfield): There is no additional report.

ACTING PRESIDENT SCHAAF: The report of

the Subcommittee on Public Health appears on page 145 of the April JOURNAL and will be referred to Reference Committee "E". There is no supplemental report. The report of the Subcommittee on Public Relations is on page 145 of the JOURNAL, and it will be referred to Reference Committee "E". Dr. Sica, is there any additional report?

DR. L. SAMUEL SICA (Trenton): There is no additional report.

ACTING PRESIDENT SCHAAF: We now come to the Advisory Committees to the Subcommittee on Medical Practice and Public Health. The reports are on pages 146 to 160 of the April JOURNAL. We will not call each of these separately. I will ask whether there are any supplemental reports for any of the Advisory Committees to the Subcommittee on Medical Practice and Public Health. Hearing none, we will proceed to the report of the Annual Meeting Committee by Dr. Murray. The original report appears on page 142 of the April JOURNAL, and it will be referred to the Reference Committee on Miscellaneous Business.

DR. HARROLD A. MURRAY (Newark): There is no supplemental report.

ACTING PRESIDENT SCHAAF: The Secretary will now read the action of the Board of Trustees in regard to honorary memberships at its meeting March 16, 1947.

DR. STAHL: *"Honorary Memberships:* Dr. Hawkes, Chairman of the Honorary Membership Committee, reported that we had received a recommendation from the Welfare Committee nominating Mr. William H. MacDonald, of the State Department of Health, for honorary membership in The Medical Society of New Jersey. Dr. Hawkes recalled that last year Mr. John S. Thompson, a member of the Board of Trustees of the Medical-Surgical Plan, had been suggested for honorary membership. Dr. Hawkes recommended that, in the event of an amendment to the Constitution permitting the election of nonmedical persons as honorary members of The Medical Society of New Jersey is passed at the forthcoming meeting of the House of Delegates, Mr. Thompson's nomination be given preference.

"Dr. Schaaf moved that the Board of Trustees approve the recommendation of the Honorary Membership Committee as it applies to Mr. Thompson and that Mr. MacDonald be considered in 1948 with special preference. Seconded and unanimously carried."

DR. E. ZEH HAWKES (Newark): At the annual convention of this Society a year ago it was desired to elect Mr. John S. Thompson, who at present is President of the Mutual Benefit Life Insurance Company, to honorary membership in recognition of the very great service he had done to the Medical-Surgical Plan in guiding its actuarial policy. This service was given at great expenditure of his ability and his time. At that time it was found impossible to elect him because our Constitution and By-Laws provide that an honorary member must be a physician. Subsequently it has been planned to change our By-Laws at this convention so that a nonmedical man may be made an honorary member, and the report of this committee is contingent upon this action being taken at this meeting of our Society.

Since our last convention, the name of Mr. MacDonald, of the State Board of Health, was presented by the Welfare Committee, and the Honorary Membership Committee felt very cordial toward that suggestion, also.

When we reported to the Board of Trustees at its March meeting, the two names were presented. It was suggested that if two cannot be elected at this time, Mr. MacDonald be carried over and be a candidate for choice at our 1948 convention.

The committee therefore presents the name of Mr. Thompson for your favorable consideration, which, as I said, is entirely contingent upon the change in our Constitution to allow it.

ACTING PRESIDENT SCHAAF: The report of the Committee on Honorary Membership will be referred to the Reference Committee on Resolutions and Memorials.

We will now call for resolutions to be referred to appropriate Reference Committees. The first resolution comes from Essex County, and I will ask Dr. Harvey, as leader of that delegation to read this resolution.

DR. THOMAS W. HARVEY, JR. (Orange): Essex County wishes to recommend the following resolution:

"That The Medical Society of New Jersey remit the dues of those veteran members who are taking full-time graduate training under Public Law 346, and who are not in the private practice of medicine."

ACTING PRESIDENT SCHAAF: You have heard the resolution. What is your pleasure?

(Upon motion, regularly seconded, put to a vote and carried, it was voted to refer the resolution to the appropriate Reference Committee.)

Dr. Harvey then read the following resolution:

RESOLUTION "A" FROM ESSEX COUNTY MEDICAL SOCIETY

The Essex County Medical Society submits the following resolution for consideration and approval

by The Medical Society of New Jersey, with the request, that, should they concur with the resolution, it should be presented by its delegates to the A. M. A. at its annual meeting.

Whereas the new social philosophy being evolved in this country has confronted organized medicine with many vital and perplexing problems and

Whereas the burden of meeting these problems, and at the same time retaining those attributes which experience has thought are vital in maintaining the standards of medical care, it now being borne almost entirely by the more mature members of our profession, and

Whereas it is recognized that the doctor of tomorrow who is the student of today, will be the future standard-bearer of our profession and

Whereas there is a formative period of six to eight years wherein as student and intern, the doctor receives his scientific training and lays the foundation for his professional philosophy, and

Whereas we believe that to prepare the physician to carry on the work now being performed by organized medicine, his curriculum should be supplemented by a program that would indoctrinate him with the philosophy and ethics of our organization. This program should emphasize the relationship to, and the responsibility of the doctor in meeting the social problems now confronting our profession.

Therefore be it resolved that the A. M. A. inaugurate a program which will systematically make contact with every medical student in each approved medical school, and with those recently graduated, now serving internships or partaking of other post-graduate training. This program should be designed to supplement his scientific training with such facts and information as will fulfill the desires incorporated in this resolution. Preference should be given to a brief recognized course of instruction within the curriculum of each approved medical school, or by any other practical means deemed proper by the A. M. A.

Acting President Schaaf: You have heard the resolution submitted by Essex County. A motion to refer it to the appropriate Reference Committee will be in order.

Dr. David B. Allman (Atlantic City): I so move.

Dr. H. Roy Van Ness (Newark): I second the motion.

(The question was called for, and the motion was put to a vote and carried.)

Acting President Schaaf: Dr. Nichols, from Monmouth County, has a resolution which I shall ask him to present to the House of Delegates.

Dr. Stanley H. Nichols (Long Branch): We in Monmouth County were very much impressed by Dr. Sprague's recent article * in the Journal concerning the physician and his social responsibility, and we have drafted a resolution for the consideration of the House of Delegates to implement that into positive action.

RESOLUTION "B" FROM MONMOUTH COUNTY MEDICAL SOCIETY

Whereas the recent national election has provided a year or two of "breathing space" for the medical profession to make good medical services more available to all people in New Jersey at all income levels, particularly in low income families, and

Whereas it is essential that more effective means be provided at once to accomplish this goal, with the aid of our allied professions and all public and private agencies concerned with this outstanding problem, therefore

Be It Resolved that, to accomplish this purpose, the President of The Medical Society of New Jersey appoint a special state society Committee for Medical Care (of seven of the most able members of the Society), to include five Past Presidents, to lay out a complete detailed plan for good medical care for every person in New Jersey,—the plan to be ready within ninety days: this Committee to have all facilities and staff of the Society placed at its disposal to expedite the study, and

Be It Further Resolved that for use as soon as this plan is ready, the House of Delegates of The Medical Society of New Jersey include the sum of $20,000.00 in the budget for the coming year, and direct that it shall be efficiently used by the Public Relations Committee to employ a professional public relations expert to establish as promptly as possible at state, and at the twenty-one county levels, a sound complete program, which will make available good medical services to all people in New Jersey, particularly in low income families, and

Be It Further Resolved, that the Public Relations Committee, working with the public relations committees of the county medical societies, shall create a state and county working relationship with the health professions, the governmental and private agencies, and the organizations representing the larger consumer groups, to meet this outstanding need in a manner that will convince the entire public of this state of the sincerity and ability of the medical profession to see that good medical services are made available to every person at any income level in this state, whenever such person shall make it known to any county medical society or the State Medical Society that good medical services are not available to them.

Suggested Budget Items

Trained Public Relations Expert.....	$10,000.00
State and Administrative Office Expenses	5,000.00
State Public Relations Assistance to Twenty-one County Medical Societies Public Relations Program	5,000.00
	$20,000.00

* Page 90, March 1947 Journal.

DR. NICHOLS (Continuing): This was adopted by the Monmouth County Medical Society March 26, 1947.

ACTING PRESIDENT SCHAAF: A motion will be in order to refer this to the Reference Committee on Resolutions and Memorials.

(Upon motion, regularly seconded, put to a vote and carried, it was voted to refer Resolution B to the appropriate Reference Committee.)

ACTING PRESIDENT SCHAAF: We have resolutions submitted by Union County, and I will ask Dr. Murphy if he will read them.

DR. HERSCHEL S. MURPHY (Roselle): The Union County Medical Society at a regular meeting adopted two types of resolutions in regard to medical fees. The first is a resolution on compensation fees.

RESOLUTION G

Resolved: That The Medical Society of New Jersey in meeting assembled, go on record as approving an increase in medical compensation fees. We recommend that the increased fees be comparable to the Veterans Administration Fee schedule (agreed to by the Veterans Administration and The Medical Society of New Jersey) and the fees charged by the doctors of New Jersey to their private patients. Fees for court testimony, minor operative work and major operations should be increased in like proportion.

Be it further resolved that: a copy of this resolution be sent to: the Newark Claim Managers Counsel; the New Jersey Claim Association; the Association of Self Insurers; the American Mutual Liability Insurance Co., Newark, N. J.; the Liberty Mutual Insurance Co., Newark, N. J.; Lumberman's Mutual Insurance Co., Newark, N. J.; and the New Jersey Manufacturers Casualty Insurance Co., Trenton, N. J.

(Upon motion, regularly seconded, put to a vote and carried, it was voted to refer the resolution to the appropriate Reference Committee.)

DR. MURPHY: We have another resolution which is worded a little bit differently, but H and G are the same. It is a resolution on fees from life insurance companies.

RESOLUTION H

Whereas the Tennessee Medical Association adopted the following resolution and whereas the principles involved in this Resolution have been approved by the Union County Medical Society with the recommendation that The Medical Society of New Jersey be asked to adopt the following resolutions:

"Resolved, that it is the sense of the Tennessee State Medical Association in meeting assembled that we deplore the injustice of the insurance companies of America toward the members of the medical profession in their failure to raise the five dollar fee paid for medical examinations for more than seventy-five years. This rank unfairness is accentuated by the fact that the entire financial structure of life insurance is erected and its solvency based on the integrity and professional ability of the examining physician. Moreover this flagrant violation of fair practice on the part of all life insurance companies is made more glaring by the fact that no account is taken of the increased cost of medical education, medical equipment and medical expenses, including the transition from the horse and buggy to the automobile age."

Be it further resolved that the fee for a life insurance examination be raised to ten dollars with all other medical insurance fees to be increased in like proportion.

A copy of this resolution to be sent to:
Equitable Life Insurance Co., New York.
Metropolitan Life Insurance Co., New York.
The Penn Mutual Life Insurance Co., Philadelphia, Pa.
The Connecticut Mutual Life Insurance Co., Hartford, Conn.
Massachusetts Mutual, Springfield, Mass.
Prudential Life Insurance Co., Newark, N. J.
John Hancock, Boston, Mass.
Mutual Benefit Life Insurance Co., Newark, N. J.

(Upon motion, regularly seconded, put to a vote and carried, it was voted to refer the resolution to the appropriate Reference Committee.)

ACTING PRESIDENT SCHAAF: We will now call for amendments to the Constitution and By-Laws, and I shall ask the Secretary to read for the second time a proposed amendment to the Constitution which was passed at our last meeting of the House of Delegates.

DR. STAHL: The following proposed amendment to the Constitution was approved by the House of Delegates at the 1946 Annual Meeting, and it will be presented for final approval at the meeting in April 1947. The proposed amendment is now read in compliance with the constitutional provision to that effect. The proposal would add certain phrases * to Section 5 of Article IV of the Constitution. The Article would then read, as amended:

"Honorary members shall be physicians and surgeons who have attained distinction within the medical profession, *or nonmedical persons who have rendered signal service to The Medical Society of New Jersey or who have attained special eminence in scientific fields other than medicine,* and who may

* The added phrases are in italics.

be elected by a two-thirds vote of the House of Delegates after having been recommended by the Committee on Honorary Membership; provided the number of living Honorary Members does not exceed fifteen. They shall have all the privileges of members but shall not be members of the corporate body."

Acting President Schaaf: This proposed change in the Constitution and By-Laws has been submitted for a second reading as required by our procedure. It will be referred to the Committee on Consitution and By-Laws and will return to the House of Delegates for final ballot on Thursday.

There are two other proposed changes in the Constitution. One is a change in the Constitution which is offered by Essex County, and I shall ask Dr. Harvey to present that.

Dr. Harvey: The Essex County delegation voted to submit a resolution changing the Constitution by creating a class of emeritus members. There are certain members of this Society who have retired because of age or disability; there are others who became permanently disabled during the last war. They are often carried as honorary members by the county society, and it seems fitting that a new class called emeritus members be formed to include them. The resolution is as follows:

PROPOSED AMENDMENT ON EMERITUS MEMBERS

The delegates from Essex County offer the following addition to the Constitution and By-Laws. Under Article IV we recommend the addition of a section to provide for emeritus membership. This provision should read as follows:

Section 7—*Emeritus Membership*

The emeritus membership group shall include physicians who have been members in good standing of a component county society for at least twenty years, and who, by reason of age or infirmity, have retired from the active practice of medicine, or members of the Society who have been disabled by reason of military service. They shall have all the privileges of membership, but their respective component societies shall not be assessed for such members, provided they are carried as emeritus members in their component societies. The emeritus members shall not be included in the membership of a component county society when computing the number of delegates to which such society is entitled.

Acting President Schaaf: This is a proposed change in the Constitution which requires reading at two successive annual conventions and must be passed finally at this meeting of the House of Delegates.

(Upon motion, regularly seconded, put to a vote and carried, it was voted to refer the proposed amendment to the Committee on Constitution and By-Laws.)

Dr. Ralph K. Hollinshed (Westville): I have been asked to offer the following change in the By-Laws. If adopted it would be a new paragraph in section 5 of Chapter VI of the By-Laws. The proposed new By-Law is as follows:

Term of Office:—A Trustee shall not hold office for more than two elected terms nor serve for a total of more than six years as an elected or appointed Trustee.

This, it is proposed, would become paragraph (b) of section 5, Chapter VI. The present paragraph (b) would then become paragraph (c) and so on, the present final paragraph (f) becoming, of course, paragraph (g).

Acting President Schaaf: This proposed amendment can be considered and passed by the House of Delegates at a single convention, and it can become immediately effective. A motion to refer it to the Committee on Constitution and By-Laws is in order.

(Upon motion, regularly seconded, it was voted to refer the proposed amendment to the Committee on Constitution and By-Laws.)

Acting President Schaaf: I now call on Dr. Scott for a supplementary report for the Medical Service Administration and the Medical-Surgical Plan.

(Dr. Scott read the report on the Medical-Surgical Plan.)

MEDICAL-SURGICAL PLAN OF NEW JERSEY

(A New Jersey Corporation)

Balance Sheet December 31, 1946

ASSETS

Cash in banks and on hand		$106,751.01
Accounts Receivable		63,417.39
United States Government obligations at amortized cost ($102,002.50 at December 31, 1946, market quotations)	$101,711.76	
Accrued interest receivable	1,145.90	
		102,857.66
		$273,026.06

LIABILITIES AND RESERVES

Provision for medical and surgical claims	$ 70,047.85
Sundry accounts payable	7,413.35
Provision for state and federal social security taxes and employees' taxes withheld	346.24

Unearned subscription income	24,822.14
Total	$102,629.58
Reserves, including legal reserve required by Insurance Laws of the State of New Jersey, per accompanying statement	170,396.48
	$273,026.06

STATEMENT OF RESERVES
FOR THE YEAR ENDED DECEMBER 31, 1946

Reserves, January 1, 1946		$ 90,241.37
OPERATIONS OF PLAN:		
Subscription Income earned	$540,227.83	
Less:		
Medical and surgical claims (paid or accrued)	$370,576.10	
Operating expenses	90,937.58	
	461,513.68	
Increase in reserves from operations of Plan		78,714.15
INVESTMENT INCOME:		
Interest Earned		1,440.96
RESERVES, December 31, 1946		$170,396.48

To the Trustees of Medical-Surgical Plan of New Jersey:

We have examined the balance sheet of MEDICAL-SURGICAL PLAN OF NEW JERSEY as of December 31, 1946, and the statement of reserves for the year then ended, have reviewed the system of internal control and accounting procedures of the Plan and, without making a detailed audit of the transactions, have examined or tested accounting records and another supporting evidence, by methods and to the extent we deemed appropriate. We obtained confirmation from the various depositaries of the amounts of cash on deposit at December 31, 1946, and on February 13, 1947, we examined the United States Government obligations owned by the Plan. Our examination was made in accordance with generally accepted auditing standards applicable in the circumstances and included all procedures which we considered necessary.

In our opinion, the above balance sheet and related statement of reserves present fairly the position of Medical-Surgical Plan of New Jersey at December 31, 1946, and the results of its operations for the year then ended.

Lybrand, Ross Bros. and Montgomery
New York, April 7, 1947.

REPORT AS OF MARCH 31, 1947

ENROLLMENT	Contracts	Persons
In Force at March 31, 1947	44,883	101,078
Enrolled in Advance (not effective 3/31/47)	2,038	4,108
Total Enrolled at March 31, 1947	46,921	105,186

ASSETS

Cash (working funds)	$ 92,684.30
Cash (savings banks)	10,225.00
Investments (U. S. Government Bonds)	142,985.33
Accrued Interest	929.76
Subscription payment on deposit in Hospital Plan account	70,438.92
Accounts Receivable—Subscriptions	3,889.49
Total	$321,152.80

LIABILITIES

Unearned Subscriptions	$ 32,966.02
Claims Outstanding	
Reported	57,083.50
Unreported	25,000.00
Unpaid Expenses	
Hospital Service Plan of N. J.	8,191.10
Other	807.96
Reserve	197,104.22
Total	$321,152.80
Reserved per enrolled person	$ 1.95

CLAIM EXPERIENCE MARCH 1947

Earned Subscriptions	(100%)	$ 68,259.14
Claims Incurred	(68.3%)	46,604.78
Net Operating Expense	(17.7%)	12,088.51
Total	(86%)	$ 58,693.29
Earned Reserves	(14%)	$ 9,565.85
Interest on Investments		231.94
Total Reserve for Month		$ 9,797.79

ACTING PRESIDENT SCHAAF: This supplemental report of the Medical Service Administration and the Medical-Surgical Plan will be referred to Reference Committee "C", along with the original report which was published on page 162 of the April JOURNAL. If there is nothing further, the House of Delegates will recess until twelve-thirty tomorrow, when we will convene here for the purpose of the annual election.

(The meeting adjourned at twelve-thirty o'clock.)

Wednesday Afternoon Session—April 23, 1947

The second session of the House of Delegates convened at twelve-thirty o'clock, Dr. Frank G. Scammell, President of the Society, presiding.

PRESIDENT SCAMMELL: Gentlemen, first I wish to introduce some of our visiting brothers, and it gives me great pleasure to introduce to you the representatives from New York—Dr. W. P. Anderton (Applause) and his guest, Dr. J. S. Kenney. (Applause.)

DR. W. P. ANDERTON (Secretary, Medical Society of the State of New York): It gives me great pleasure to express the appreciation of the Medical Society of the State of New York for your kind invitation to send representatives here to your meeting. I enjoyed your hospitality last year, and I can only say that my heart was full of praise for your grand organization at that time. Dr. Louis Bauer, our president, was sorry that he could not come to this meeting. He had to go away a couple of weeks ago to represent the American Medical Association at what was expected to be the formation of an International Medical Association. Dr. Cunniffe, our past-president, was also down to visit with us today, but he has been detained by important operative work in the Bronx and his preparation of the report for the Judicial Council of the American Medical Association.

When I say that those of us in New York admire not only your state but your medical organization and profession, I put it very mildly. We admire your ability individually and collectively, we admire your way of doing business in your House of Delegates, and we admire the cohesive way that you behave in public; to wit, for instance, the way your Senator Smith behaved a year ago. He certainly did a swell job for the whole profession when it came to the Murray-Wagner-Dingell Bill, and I have no doubt that what he did was largely at the instigation of your Society.

Again allow me to express not only my own appreciation, but that of the Medical Society of the State of New York for inviting us here. (Applause.)

PRESIDENT SCAMMELL: Thank you very much, Dr. Anderton, for your kind remarks and also those solicitious remarks telling us how good we are.

(Acting President Schaaf took the chair.)

ACTING PRESIDENT SCHAAF: The only business which can be conducted at this session of the House of Delegates is the regular annual election. I first ask the Secretary, whether a quorum is present.

DR. ALFRED STAHL (Secretary, Newark): A quorum is present.

ACTING PRESIDENT SCHAAF: Thank you, We will now call for the report of the Nominating Committee by its chairman, Dr. Alexander.

DR. SAMUEL ALEXANDER (Junior Past-President, Park Ridge): Mr. President and delegates to the convention: The Nominating Committee met last night, and the following is its report:

OFFICE	TERM	
President-Elect	1 year	J. Howard Hornberger, M.D.
1st Vice-President	1 year	James F. Norton, M.D.
2nd Vice-President	1 year	Aldrich C. Crowe, M.D.
Secretary	1 year	Earl LeRoy Wood, M.D.
Treasurer	1 year	George J. Young, M.D.
Trustees:		
1st District	3 years	William F. Costello, M.D.
2nd District	3 years	Joseph G. Coleman, M.D.
	1 year	Sigurd W. Johnsen, M.D.
3rd District	3 years	George W. Fithian, M.D.
	1 year	L. Samuel Slca, M.D.
5th District	3 years	David B. Allman, M.D.
Councilors:		
1st District	1 year	Francis C. Weber, M.D.
2nd District	3 years	Vincent P. Butler, M.D.
5th District	3 years	Chester I. Ulmer, M.D.
A. M. A. Delegate (1948-9)	2 years	Ralph K. Hollinshed, M.D.*
A. M. A. Alternate (1948-9)	2 years	Joseph F. Londrigan, M.D.
A. M. A. Delegate (1948-9)	2 years	William F. Costello, M.D.
A. M. A. Alternate (1948-9)	2 years	Thomas J. Walsh, M.D.
A. M. A. Delegate (1947-8)	1 year	Elmer P. Welgel, M.D.

* Dr. Hollinshed declined the nomination.

A. M. A. Alternate (1947-8)	1 year	J. Wallace Hurff, M.D.
New York Delegate	1 year	James F. Norton, M.D.
New York Alternate	1 year	D. Ward Scanlan, M.D.
Connecticut Delegate	1 year	Alfred Stahl, M.D.
Connecticut Alternate	1 year	C. Byron Blaisdell, M.D.
Standing Committees:		
Finance and Budget	5 years	Anthony J. Conty, M.D.
Publication	3 years	J. Lawrence Evans, M.D.
Scientific Work:		
4th District	5 years	S. Emlen Stokes, M.D.

ACTING PRESIDENT SCHAAF: Thank you, You have heard the report of the Nominating Committee. A motion to receive the report is in order.

(Upon motion, regularly seconded, and carried, it was voted to receive the report of the Nominating Committee.)

ACTING PRESIDENT SCHAAF: For President-Elect for one year, Dr. J. Howard Hornberger. Are there any additional nominations from the floor for the position of President-Elect?

It has been moved and seconded that the nominations for President-Elect be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For First Vice-President, Dr. James F. Norton. Are there any further nominations? It has been moved and seconded that the nominations be closed, with Dr. James F. Norton as the sole candidate, and that the ballot be cast by the Secretary.

(The motion was put to a vote and carried.)

For Second Vice-President, Dr. Aldrich C. Crowe. Are there any additional nominations from the floor? It has been regularly moved and seconded that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Secretary for one year, Dr. Earl LeRoy Wood. Are there any nominations from the floor? It has been moved and seconded that the nominations for Secretary be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Treasurer for one year, Dr. George J. Young. Are there any additional nominations from the floor? It has been moved and seconded that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Trustee from the First District, for three years, Dr. William F. Costello. Are there any additional nominations from the floor? It has been moved and seconded that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Trustee from the Second District, for three years, Dr. Joseph G. Coleman. Are there any nominations from the floor? It has been moved and seconded that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Trustee from the Second District, for one year, Dr. Sigurd W. Johnsen. Are there any nominations from the floor? Will someone move that they be closed and that the Secretary cast the ballot?

(Upon motion regularly seconded, put to a vote and carried, it was voted that the nominations be closed and the Secretary instructed to cast the ballot.)

For Trustee from the Third District, for three years, Dr. George W. Fithian. Are there any nominations from the floor? It has been moved and seconded that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Trustee from the Third District, for one year, Dr. L. Samuel Sica. Are there any other nominations? It has been moved and seconded that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Trustee from the Fifth District, for three years, Dr. David B. Allman. Are there any additional nominations? It has been moved and seconded that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Councilor from the First District, one year, Dr. Francis C. Weber. Are there any nominations from the floor? It has been moved and seconded that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Councilor from the Second District, three years, Dr. Vincent P. Butler. Are there

any nominations from the floor? It has been regularly moved and seconded that the nominations be closed and the Secretary cast the ballot.

(The motion was put to a vote and carried.)

For Councilor from the Fifth District, for three years, Dr. Chester I. Ulmer. Are there any additional nominations? It has been moved and seconded that the nominations be closed and the Secretary cast the ballot.

(The motion was put to a vote and carried.)

Delegates and Alternates to the 1948 and 1949 meetings of the A. M. A. Dr. Ralph K. Hollinshed has withdrawn his name immediately as the Delegate for two years. Are there any nominations in place of Dr. Hollinshed?

Dr. James F. Norton (Second Vice-President, Jersey City): Mr. President and Members of the House of Delegates: In view of the vacancy caused by the refusal of Dr. Hollinshed to accept renomination, I have the opportunity to place in nomination the name of Dr. Joseph F. Londrigan. In presenting his name, I do so with a full realization and a deep sense of my duty to The Medical Society of New Jersey, feeling that at no time within my memory has the need of organized medicine for vigorous, competent, well-directed leadership been so demanding as at the present moment. I feel that if you see fit to accept the name of Dr. Londrigan, you will be doing credit to the State Society. I don't now have to go into detailed eulogy of his accomplishments, his potentialities, and what he has contributed. It is enough to tell you that he has served you well as President and is preëminently fitted to represent you in Chicago. With the hope that you will look with favor upon him, I offer you Joseph F. Londrigan.

Dr. Martin H. Collier (Camden): Feeling, as I do, in perfect accord with Dr. Norton, may I have the privilege of seconding the nomination of Dr. Londrigan.

Acting President Schaaf: Are there any other nominations for A. M. A. delegate for two years? It has been moved that the nominations be closed and the Secretary instructed to cast the ballot.

(The motion was put to a vote and carried.)

Delegate for two years, Dr. William F. Costello. Are there any other nominations from the floor? It has been moved and seconded that the nominations be closed and that the Secretary be instructed to cast the ballot.

(This motion was put to a vote and carried.)

Delegate for the 1947 and 1948 meetings, one year, Dr. Elmer P. Weigel; Alternate, Dr. J. Wallace Hurff.

Dr. Henry C. Barkhorn (Newark): Essex County has a candidate to present from the floor. There is little need to enlarge on the virtues of our candidate and give him a "build-up". He is well known to all of you and represents the progressive element in The Medical Society of New Jersey. He has long been interested in medical economics and in public relations, some areas of which the A. M. A. is just now beginning to explore and in which he will be extremely interested and helpful. This is the time for the House of Delegates to decide what representation we need in our parent organization. We have a man with the vision, scope, and ability to plan. I present the name of J. Wallace Hurff to fill the unexpired term of New Jersey's Wells P. Eagleton.

Dr. Harrold A. Murray (Newark): I second the nomination of Dr. J. Wallace Hurff.

Acting President Schaaf: The nomination of Dr. J. Wallace Hurff has been made and seconded. Are there any other nominations?

Dr. Marcus W. Newcomb (Browns Mills): Mr. President and Delegates: Dr. Weigel, who was nominated by the Nominating Committee, has been Alternate for fourteen years. He has attended this Society's meetings regularly for the last twenty-six years. He has attended two American Medical Association meetings. He has been president of the Union County Medical Society, and is well versed in medical subjects. It seems to me that if we are going to have able men elected as Alternate, when there is a vacancy as Delegate someone should not be put in over a man with fourteen years' service. I don't think any of you would dispute that Dr. Weigel is perfectly able to fill this position. I don't know Dr. Hurff and have never met him, and there is nothing personal about this with me, but it seems to me that this Society should have a practice of elevating their Alternates if we expect to have good men as Alternates. Ability being equal, I think that we should elect Dr. Weigel as Delegate to the A. M. A. after fourteen years of service as an Alternate. (Applause.)

Acting President Schaaf: Are there any additional nominations? I hear none. We will take a ballot, and I appoint Dr. Quigley and Dr. Alexander as tellers.

(Ballot is taken.)

I ask the Secretary the results of the ballot.

Dr. Stahl: For Dr. Hurff, 94 votes; for Dr. Weigel, 79.

Acting President Schaaf: The Chair de-

clares Dr. Hurff elected as Delegate to the American Medical Association. We will proceed with the selection of Delegates to other state societies. To New York State, for Delegate Dr. Norton, for Alternate, Dr. Scanlan. Are there any additional nominations? It has been moved and seconded that nominations be closed.

(The motion was put to a vote and carried.)

ACTING PRESIDENT SCHAAF: Delegates to the Connecticut Society, Dr. Stahl and Dr. Blaisdell. Are there any nominations from the floor? I hear a motion that nominations be closed.

(This motion was put to a vote and carried.)

ACTING PRESIDENT SCHAAF: For Finance and Budget Committee, for five years, Dr. Anthony J. Conty. Are there any additional nominations from the floor? It has been moved and seconded that the nominations be closed and the Secretary be instructed to cast the ballot.

(The motion was put to a vote and carried.)

For the Publication Committee, for three years, Dr. J. Lawrence Evans. Are there any nominations from the floor? It has been moved and seconded that the nominations be closed and that the Secretary be instructed to cast the ballot.

(The motion was put to a vote and carried.)

Scientific Work, from the Fourth District, for five years, Dr. S. Emlen Stokes. Are there any additional nominations from the floor? It has been moved and seconded that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

ACTING PRESIDENT SCHAAF: Owing to the elevation of Dr. David B. Allman, who was elected the Trustee from the Fifth District on the Board of Trustees, there is a vacancy on the Finance and Budget Committee and nominations for that office are now in order.

DR. NORTON: I wish to place in nomination the name of Dr. Luke A. Mulligan.

From the floor: I second the nomination.

ACTING PRESIDENT SCHAAF: The name of Dr. Mulligan has been placed in nomination. Are there any additional nominations for this office? It has been moved that the nominations be closed and that the Secretary cast the ballot.

(The motion was put to a vote and carried.)

ACTING PRESIDENT SCHAAF: We can return now to the Alternate Delegates. The first is an Alternate Delegate for Dr. William F. Costello. Are there any additional nominations from the floor for this office? It has been moved and seconded that the nominations be closed and that the Secretary be instructed to cast the ballot.

(The motion was put to a vote and carried.)

ACTING PRESIDENT SCHAAF: The other two Alternate Delegates will be open for nomination now. We can proceed with the nominations for an Alternate for Dr. Londrigan.

DR. THOMAS W. HARVEY (Orange): I nominate Dr. Ralph K. Hollinshed of Gloucester County.

DR. NORTON: I second the motion.

ACTING PRESIDENT SCHAAF: Are there any additional nominations? It has been regularly moved and seconded that the nominations be closed and that the Secretary be instructed to cast the ballot for Ralph K. Hollinshed.

(The motion was put to a vote and carried.)

DR. D. L. HAGGERTY (Trenton): There is a vacancy on the Advisory Committee to the Woman's Auxiliary.

ACTING PRESIDENT SCHAAF: The Nominating Committee has not submitted names. Apparently there has been an omission from the report of the Nominating Committee in regard to the Advisory Committee for the Woman's Auxiliary. Dr. Dodd is nominated for that office for a term of three years. Are there any additional nominations for that position? It has been moved and seconded that the nominations be closed and that the Secretary be instructed to cast the ballot.

(The motion was put to a vote and carried.)

ACTING PRESIDENT SCHAAF: Dr. Dodd is elected. This concludes the election.

(The meeting adjourned at one-fifty o'clock.)

Thursday Afternoon Session—April 24, 1947

The third session of the House of Delegates convened at one-forty o'clock, Dr. Royal A. Schaaf, Newark, Acting President of the Society, presiding.

ACTING PRESIDENT SCHAAF: The meeting will please come to order. We will call for the reports of the Reference Committees, and the first will be the Reference Committee on Constitution and By-Laws, under Dr. Sprague.

(Dr. Edward W. Sprague, Newark, read the introductory paragraph and paragraph I of the report of the Reference Committee on Constitution and By-Laws.)

REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

The Reference Committee on Constitution and By-Laws met on April 22, 1947. Present were: Dr. George F. Dandois, Dr. Charles Butcher, Dr. Abraham E. Jaffin and Dr. Edward W. Sprague, chairman.

The following proposed changes to the Constitution and By-Laws were considered:

1. *Proposed amendment to the Constitution.*

The following proposed amendment to the Constitution was approved by the House of Delegates at the 1946 Annual Meeting and is presented for final approval today. It was published in the January JOURNAL in compliance with the constitutional provision. (The italicized phrases represent proposed additions to Section 5 of Article IV of the Constitution.)

"Honorary members shall be physicians and surgeons who have attained distinction within the medical profession, or *nonmedical persons who have rendered signal service to The Medical Society of New Jersey or who have attained special eminence in scientific fields other than medicine,* and who may be elected by a two-thirds vote of the House of Delegates after having been recommended by the Committee on Honorary Membership; provided the number of living Honorary Members does not exceed fifteen. They shall have all the privileges of members but shall not be members of the corporate body."

This proposed amendment is approved by the Reference Committee and recommended for adoption by the House of Delegates.

DR. SPRAGUE (Continuing): I would like to move that we adopt this amendment.

(The motion was regularly seconded, put to a vote and carried.)

ACTING PRESIDENT SCHAAF: It is so ordered. This amendment now becomes effective immediately. Having been read at the last meeting of the last convention, having been published as required and now having been reread and adopted, it is now an effective part of our Constitution and under it we may elect honorary members who are not physicians.

Dr. Sprague read paragraph 2 of his report.

2. *Proposed amendment to the By-Laws.*

Chapter 6, Section 5, Board of Trustees—item (b) should read:

(b) "Term of Office: A Trustee shall not hold office for more than two elected terms nor serve for a total of more than six years as an elected or appointed trustee."

The Reference Committee disapproves of this proposed amendment to the By-Laws. It is presented as a matter relating to By-Laws, whereas in the opinion of this Reference Committee it is a matter relating to the Constitution. Article VI of the Constitution specifically refers to length of service of the Trustees.

DR. SPRAGUE: I move the approval of this recommendation of the Reference Committee.

ACTING PRESIDENT SCHAAF: It is moved and seconded that this portion of the report of the Constitution and By-Laws Committee be approved. Is there any discussion?

(The question was called for, and the motion was put to a vote and carried.)

ACTING PRESIDENT SCHAAF: It is so ordered.

Dr. Sprague read paragraph 3 of his report.

3. *Emeritus Membership.*

The Delegates from Essex County offer the following proposed addition to the Constitution and By-Laws. Under Article IV they recommend the addition of a section to provide for emeritus membership.*

This Reference Committee approves the aims and principles of this proposed amendment to the Constitution. In the opinion of the Committee the proposed amendment contains conflicting meanings. To clarify the amendment we recommend the sentence—"They shall have all privileges of membership" be changed to read—"They shall have all privileges of membership except the right to vote and to hold office".

This Reference Committee recommends the adoption of the proposed amendment with the above change.

* See page 14 these TRANSACTIONS.

DR. SPRAGUE (Continuing): The Reference Committee recommends the adoption of the proposed amendment with the above change. I so move, Mr. President.

ACTING PRESIDENT SCHAAF: It has been moved and seconded that this section of the report of the Constitution and By-Laws Reference Committee be approved. Is there any discussion?

DR. JOHN SMITH (Middlesex County): We are in the process of revamping our constitution and by-laws of the Middlesex county society. According to the proposed amendment here, such a member must be carried by his component county society as an emeritus member. I don't believe many of the county societies have that classification of membership. It would mean that they would have to change the county constitutions and by-laws to correspond to this.

ACTING PRESIDENT SCHAAF: That is correct, there would have to be a similar provision in the home society constitution and by-laws to implement this.

DR. SMITH: Thank you.

FROM THE FLOOR: I think it is a mistake to carry away the idea that there is any compulsion on the part of any county society to create such a classification. This classification emanates spontaneously from such component societies as have members whom they wish to take care of without burden to the Society. Therefore, I think there is a misunderstanding on the part of the gentleman from Middlesex that it would complicate their new constitution and by-laws. They will create it whenever there is a need for it.

PRESIDENT SCAMMELL: I would like to know if this amendment has anything especially to do with your age.

ACTING PRESIDENT SCHAAF: It has nothing to do with age. Only a man who requested that he be placed in emeritus membership because he was aged or infirm would be so placed, at his own request.

PRESIDENT SCAMMELL: He would have to request it.

ACTING PRESIDENT SCHAAF: He would have to request it.

(The question was called for, and the motion was put to a vote and carried.)

DR. SPRAGUE: Mr. President, I would like to move that the Reference Committee report be adopted as a whole.

(The motion was regularly seconded.)

ACTING PRESIDENT SCHAAF: It has been moved and seconded that the report of the Reference Committee on Constitution and By-Laws be approved as a whole. Is there any discussion?

(The question was called for, and the motion was put to a vote and carried.)

ACTING PRESIDENT SCHAAF: We will now ask for the report of the Reference Committee on Resolutions and Memorials, Dr. Cosgrove, Chairman.

DR. SAMUEL A. COSGROVE (Jersey City): Mr. President, Fellow Members of the House of Delegates of The Medical Society of New Jersey:

(Dr. Cosgrove read section 1 of the report of the Reference Committee on Resolutions and Memorials.)

REFERENCE COMMITTEE ON RESOLUTIONS AND MEMORIALS

The Committee on Resolutions and Memorials found before it three resolutions:

1. A resolution from Essex County concerning the socio-medical indoctrination of medical students and recent medical graduates by a program of intra-curricular or other instruction to be sponsored and carried out by the American Medical Association.

The Committee recommends approval and instruction of the delegates of The Medical Society of New Jersey to the American Medical Association to present this resolution to the American Medical Association at its next executive session;

DR. COSGROVE (Continuing): I move the adoption.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Cosgrove read section 2 of the report.)

2. A resolution from the Board of Trustees providing for the Society's special recognition of the fine service of Dr. Alfred Stahl during ten years of tenure as secretary of this Society.

The Committee recommends approval of this resolution, and the carrying out of its provisions;

DR. COSGROVE (Continuing): I move the adoption of this recommendation.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Cosgrove read section 3 of the report.)

3. A resolution to elect Mr. John S. Thompson an honorary member of this Society.

The Committee recommends approval of this resolution.

There were present at the meeting of the Committee: Dr. Lorimer B. Armstrong, Dr. Harold S. Hatch and Dr. Samuel A. Cosgrove.

DR. COSGROVE (Continuing): I move the adoption of this section of the report.

(The motion was regularly seconded, put to a vote and unanimously carried.)

DR. COSGROVE: I move the adoption of the entire Reference Committee report.

(The motion was regularly seconded, put to a vote and carried.)

ACTING PRESIDENT SCHAAF: Under the provision of the Constitution and By-Laws which has just been adopted, it is possible for the Society now, for the first time, to elect a nonmedical person to membership. The Committee on Resolutions and Memorials has recommended the election of Mr. John S. Thompson in recognition of his contributions to the welfare of the Society.

DR. THOMAS K. LEWIS (Camden): Mr. Chairman, Members of the House, and Guests: (Dr. Lewis read the citation.) (Applause.)

MR. JOHN SPENCER THOMPSON

In the autumn of 1938, the idea of a prepayment medical care plan to be organized by The Medical Society of New Jersey which would assist the individual in the payment of medical care was proposed by Dr. Edward W. Sprague to Dr. William J. Carrington, then President of our Society. Dr. Carrington was so impressed with this idea that he appointed a committee, under the chairmanship of Dr. Hilton S. Read, to determine the feasibility and the advisability of undertaking the creation of such a program. Dr. Read reported to the Board of Trustees that after careful consideration his committee was favorable to the institution of such a project. The President then appointed a special group for the purpose of formulating a concrete plan and, fortunately, Dr. Norman M. Scott was assigned to assist in its development. The committee undertook its work with the idea of making available to the people of New Jersey, particularly the middle and low income groups, the best type of medical care within the traditional framework of American medical practice. This group developed the Medical Service Administration of New Jersey, which was approved by the Society. This was a step forward in making medical care available to and attainable by all. Medical Service Administration now was seriously entering the field of insurance under the supervision of the State Department of Banking and Insurance, and needed the advice and guidance of an experienced actuary. The Chairman of the committee invited Mr. John Spencer Thompson, the actuary of Mutual Benefit Life Insurance Company, to help us at that time. Mr. Thompson expressed his willingness to aid in the development of our plans. The Trustees of the Society approved of and nominated Mr. Thompson as a member of the Board of Governors of Medical Service Administration and later as a member of the Board of Trustees of Medical-Surgical Plan. Since that time he has served the Society on both Boards most faithfully.

Mr. Thompson appreciates fully the aims and altruistic purposes of The Medical Society of New Jersey and also has a comprehensive understanding of the socio-economic problems that threaten the future of American Medicine. He has in every way possible encouraged us in holding to our ideals while increasing our service to the public.

Mr. John Spencer Thompson is a man of broad vision and deep sense of civic responsibility. He resides in Glen Ridge, New Jersey. He is married and the father of three children. He graduated from the University of Toronto with honors in mathematics. He has enjoyed well-earned advancements in the departments of actuary and mathematics in the insurance world, and in his field many honors, national and international, have been bestowed upon him.

In 1926 Mr. Thompson was appointed mathematician to the Mutual Benefit Life Insurance Company; in 1927 he became Vice-President; in 1941 he became a member of the Board of Directors and in 1946 was made President of that well known insurance company.

Mr. Thompson has given unstintingly of his time, strength and knowledge, and has been a most important factor in the successful development of the sound, stable and efficient status enjoyed by the Medical Service Administration and the Medical-Surgical Plan. In the development of this program of the Society his wisdom has lead us aright. By assiduously following his advice, at all times, Medical-Surgical Plan has avoided every financial difficulty. The value of his guidance cannot be overestimated.

In his nomination for election as an Honorary Member of The Medical Society of New Jersey by this House of Delegates, the Board of Trustees is expressing in a small way its heartfelt appreciation of the efforts of Mr. John Spencer Thompson in behalf of organized medicine and the people of New Jersey.

ACTING PRESIDENT SCHAAF: Thank you, Dr. Lewis. Will Mr. Thompson please come forward?

(The audience arose and applauded.)

ACTING PRESIDENT SCHAAF: Mr. Thompson, on behalf of The Medical Society of New

Jersey, it is a great pleasure and honor and privilege to welcome you to membership. It has given to you recognition of your contribution to the welfare of our Society and of the people of the State.

Mr. John S. Thompson: Thank you very much for your overgenerous introduction. It is so difficult for me to express my appreciation for what you have just done that I shall not attempt it. Suffice it to say that in the course of a fairly long and busy life, this honorary membership is, in my opinion, one of the finest things that has ever befallen me. I am convinced that my meager services to the Medical-Surgical Plan, the Medical Service Administration, and allied plans, is grossly overrated. Occasionally the fruits of forty-odd years in the life insurance business may have been brought to bear upon one of the problems before the board of one or more of these organizations; but, generally speaking, it may be said that the doctors, actuaries, financiers, and others who are working at this problem are merely seeking in a more or less groping way for a solution of the many difficulties which beset those who try to find some better way for the distribution and payment for medical care for those of moderate or low income.

Finally, I would simply add that this service for the Medical Service Administration and allied organizations has been a sort of agreeable diversion after the rather simple task of operating a life insurance company. The contact with your representatives on these boards has been a most pleasant and profitable experience, and it has been a great privilege to participate in a small way in an attempted solution of this matter of the distribution of medical care, which is so much in your minds and in the minds of the public at the present time.

I speak of a solution advisedly. Whether you like the solution or not or whether or not you like the fact that a solution is being reached, it is going to be solved and, in fact, it is being solved right now. The consequences of the solution will be of vast consequence to you, to me, and to every other citizen of this country.

I thank you again for the very great honor that has been conferred. (Applause.)

Acting President Schaaf: I want also at this time to present Mrs. Thompson to the delegates. Will you take a bow, Mrs. Thompson?

(The audience arose and applauded.)

Acting President Schaaf: We diverted from the usual order of business in order to accomplish the election of Mr. Thompson with due dignity and in view of its importance. Before proceeding with the other Reference Committee reports, I am going to ask Dr. George P. Meyer to address the delegates for a few minutes on a very important matter in relation to optometry.

Dr. George P. Meyer (Camden): Mr. Chairman, Members, and Guests: There has been of late an increase in the activity of optometrists in this State. With considerable boldness, they have collected a "slush fund" and have opened a public relations office in Trenton. From this office they have sent out propaganda to their membership in an effort to instruct them in introducing optometric methods in local communities. Further, they state that they want to educate the public to the advantages of optometry.

This year they have introduced a bill in the Legislature to encroach still further on medical practice. Thanks to the alertness of Dr. Quigley, this matter was promptly disposed of, as it was last year.

The ophthalmologists of the state were considerably perturbed. Dr. Anthony Ambrose of Newark and the Guild of Prescription Opticians of the State arranged a meeting in Newark, where they discussed these matters freely. The consensus there was put together in the form of several recommendations by Dr. Joseph H. Kler, former Chairman of the Welfare Committee. I would like to present those recommendations here, with the hope that the House of Delegates will endorse them and make them effective.

First, we would like to have our Legislative Committee instructed to scrutinize carefully, as they have in the past, all bills that bear on medical practice. Dr. Quigley is to be commended for the watchfulness that he has exercised in the past.

Second, to initiate an educational program at the state level which may be carried out by the Committee on the Conservation of Vision, under the able guidance of Dr. Elbert Sherman, its present chairman. This may take the form of informative articles directed toward the family doctor, who should be reminded of the importance of referring eye cases to the eye physician.

Third, to inform the laity of these advantages by newspaper articles and talks to representative groups such as school boards, service clubs, parent-teacher associations, and like organizations. This could be aided by planning and assistance at the county level. Dr. Kler informed me that such a program was put into effect some time ago and bore fruit. I hope

the House of Delegates will stimulate the reactivation of this committee.

Fourth, to encourage such sympathetic organizations as the Guild of Prescription Opticians in their advertising campaign, in which they have done such yeoman service for the medical man.

I want to thank the officers of the House for the privilege of addressing you on this matter. (Applause.)

ACTING PRESIDENT SCHAAF: Under the provisions of the Constitution and By-Laws, no action can be taken on this. It is submitted for information only and will have to take its course through the usual channels of the Board of Trustees and the Welfare Committee.

We will now proceed to the regular order of business and call for the report of Reference Committee "A", Dr. Ulmer.

DR. CHESTER I. ULMER (Gibbstown): Mr. President and Fellow Members of the House of Delegates: To your Reference Committee "A" were assigned the reports of the President, the Secretary, the Board of Trustees, and the Judicial Council.

Your Reference Committee "A" reviewed the President's report and approved it. We commend him for carrying on through the year in spite of ill health. We admire his generous and wholesome spirit. We note in the President's report the following statement:

"The Society has been seeking the services of an Executive Officer but up to this writing we have been unsuccessful in securing a physician who has the necessary qualifications for the position."

It is now almost five years since the death of Dr. LeRoy A. Wilkes. Since that time the work in the state office has been carried on largely by Mrs. Edith L. Madden. She has done this work in a most efficient manner. She has tact and ability. With each year's change of administration, we have learned to depend upon her ability, her experience and judgment. It is very doubtful that we will be able to secure anyone who can exceed her valuable services, even though the search continues. Your Reference Committee "A" therefore recommends that Mrs. Edith L. Madden be made Office Manager and that the office of Acting Executive officer be discontinued. We believe that the new Secretary elected yesterday, Dr. Earl LeRoy Wood, has all the qualifications necessary ably to fill the office of Secretary and absorb the duties of Executive Officer.

Mr. President, I move, sir, that this report with its recommendations be adopted.

(The motion was regularly seconded.)

ACTING PRESIDENT SCHAAF: It has been moved and seconded that this section of the report be adopted. Is there any discussion?

DR. JAMES F. NORTON (Second Vice-President, Jersey City): It is with a very real sense of misgiving that I stand to take a position contrary to the report submitted by your Reference Committee. It is true, as Dr. Ulmer has indicated, that for five years there has been a policy enunciated and formulated and to some extent followed both by the House of Delegates and by the Board of Tustees to attempt to obtain the services of what they thought was a preëminently qualified Executive Officer. We have been unable to obtain one partly because for three of those five years we were engaged, as everybody knows, in a world-wide catastrophe that made the services of the type of man that we thought we wanted unable to be obtained. Last year a committee of the Board of Trustees, of which I had the honor to be a member, interviewed and interrogated some three or four applicants for this position, and because we set up a very high standard, we found that we were unable to obtain the type of man that we thought we were justified in coming before this House of Delegates and proposing to employ.

I have a full, complete, and abiding confidence and high respect for the qualifications and ability of Mrs. Madden. I most emphatically do not believe that you now want to turn around and turn over the entire structure of public relations, executive office, outside contacts, and the over-all program of the advancement of the problems of organized medicine in this State to a private physician who because of some preëminent qualifications has been elected Secretary of this Society.

I do not believe that we have a right to expect Dr. Earl Wood or any other practicing physician in this state to embark upon a program that I believe is a full-time job and requires the services, not of any man, but of a particularly highly gifted, highly specialized type of individual who is devoting not his time now, but who has been able through the years to accumulate an experience and a background and a philosophy of the problem of public relations as it relates particularly and specifically to organized medicine. That is our problem.

We cannot do this in a niggardly fashion. I don't know the motive behind the request to impose this obligation upon Dr. Wood, but if it stems from a desire to save the salary of an Executive Officer, I tell you, you are most niggardly in your approach to the problem. I am quite mindful and conscious of the fact that only yesterday there was submitted here a

budget for the year of some $75,000. Another few thousand dollars, ten or twelve or fifteen thousand dollars, are nothing against what we hope to obtain, what we are entitled to obtain, and what we most positively must obtain from a competent Executive Officer of this Society.

So, Mr. President, I would ask for the disapproval of the imposition of the duties of an Executive Officer upon the newly elected Secretary for the reasons set forth, and I most definitely am in divergence with the tenor of the report of your Reference Committee.

ACTING PRESIDENT SCHAAF: Is there any further discussion?

DR. EDWARD W. SPRAGUE (Newark): May I ask the Chairman of the Reference Committee what was the motive for the abolition of the office of Assistant Executive Secretary?

DR. ULMER: We have no such office as Assistant Executive Secretary.

DR. SPRAGUE: Do we not have?

ACTING PRESIDENT SCHAAF: We have an Acting Executive Officer.

DR. SPRAGUE: What is Dr. Scott's official title?

ACTING PRESIDENT SCHAAF: Executive Assistant.

DR. ULMER: Assistant? I said "Acting" in my report.

DR. SPRAGUE: The reason I speak about that is that in our organization in the Medical Service Administration it has been most important in our contacts with the public that we have a representative of the Society through whom the Society offers its services to the public. I would be very reluctant to see anything happen to disturb the relationship of having Dr. Scott as an officer and having that office abolished. I think that would be a very great mistake.

One other point I would like to speak about is this: I believe that the success of preserving the present form of the practice of medicine, which we believe is best for the public and by which we believe the public receives the best type of medical care, is going to require great effort on the part of this Society, and it has to come about largely through public relations. I think we should have an Executive Secretary, a physician if possible, who is especially qualified in public relations, and I would hate to see the office abolished. Dr. Wood will perform the duties in a perfect manner, and he is very much interested in it, but we should not ask him and we can't expect him to take of his time and energy and strength to do a piece of work that is a real full-time job.

DR. ULMER: Mr. President, may I first inform Dr. Sprague that no reference was made directly or indirectly to Dr. Scott's name or position. Secondly, sir, your Reference Committee "A" made this striking proposal and recommendation with a full knowledge and accurate information that the incoming Secretary will have abundant time to devote to his new task, and enthusiasm for it, plus a tremendous amount of talent.

Am I correct, sir, in the information that I have that the committee endeavoring to secure an individual for this position has interviewed or contemplated a lay person?

ACTING PRESIDENT SCHAAF: We have.

DR. ULMER: Fellow members of the House of Delegates, a lay person has been interviewed and, it is quite possible, might be engaged. If we are going to secure a lay person, why not maintain one who has been there for a long decade, one whom we know and one who knows us, one who knows our system, one who knows our history? Why change?

We acknowledge and fully comprehend that we want someone there who has a public relations attitude. We want in there somewhere someone with an M.D. If a lay person enters our executive building, who meets him? A bevy of girls—attractive, capable, essential—but not an M.D. in the place. We have a magnificent plant, admired by the allied professions, but not an M.D. around. We propose, fellow members, in our following report to place a medical man in the state office building, to have him there either whole or part time, readily available to the profession and the public.

I wish, sir, that the vote on part one be delayed, if possible, until I present our report on the Secretary. Is that possible?

ACTING PRESIDENT SCHAAF: It is quite possible. If it involves the first part of the report in any way, it can be heard before we act finally on this. Dr. Costello?

DR. WILLIAM F. COSTELLO (Dover): May I ask whose privilege or duty it is to employ the salaried personnel of the Society?

ACTING PRESIDENT SCHAAF: The Board of Trustees.

DR. COSTELLO: Then we are wasting time.

DR. HENRY C. BARKHORN (Newark): I move that this portion of the report be tabled.

DR. SAMUEL A. COSGROVE (Jersey City): I second the motion.

ACTING PRESIDENT SCHAAF: It has been moved that this portion of the report be tabled. It is not debatable.

(The motion was put to a vote and carried.)

ACTING PRESIDET SCHAAF: It is so ordered. Are you ready to proceed, Dr. Ulmer?

(Dr. Ulmer read the portion of the committee report on the report of the Secretary.)

REPORT OF REFERENCE COMMITTEE "A"

REPORT OF THE SECRETARY

We have reviewed his report and approved it. Concerning the office of Secretary, your Reference Committee feels that the time has arrived in the progress and perspective of our State Society that the Secretary occupy an office in our building in Trenton, if not full time, certainly part time. He should be readily available to the profession and the public. It is important that a physician-official should have an office in our building rather than just a group of lay employees, efficient and essential though they may be.

We feel that the Secretary of our Society should have the qualifications of a public relations officer. He should, with ability and dignity, be able to represent our profession to the allied professions, to legislators, to educators and to the public. He should be our alert liaison between the profession and the people. This should be our Secretary and your Reference Committee feels that the State Society has at long last secured the qualified individual.

DR. ULMER (Continuing): We are grateful to Essex County. Mr. President, I move you that the report and its recommendations be adopted.

(The motion was regularly seconded.)

ACTING PRESIDENT SCHAAF: It has been moved and seconded that this portion of the report be adopted. Dr. Cosgrove?

DR. COSGROVE: The function of a Reference Committee is to consider and comment solely on matters contained in the several reports referred to it for consideration, and it has no function in initiating new matters. In both the previous section and this one it would appear as though Reference Committee "A" were proposing to make *de novo* proposals which in any regular parliamentary procedure should came before this House either as a resolution or as an expression of the Board of Trustees. I believe that this section, like the first section, from that standpoint is distinctly out of order coming from a Reference Committee.

ACTING PRESIDENT SCHAAF: I will ask the parliamentarian to come forward.

(Dr. Schaaf, Dr. Ulmer and Dr. Norton conferred.)

DR. ULMER: After conference, it has been decided (and I have agreed) to refer this matter to the Board of Trustees, to convene immediately after this session. I am wholly in accord with that procedure.

ACTING PRESIDENT SCHAAF: Dr. Ulmer moves that this matter be referred to the Board of Trustees.

(The motion was regularly seconded, put to a vote and carried.)

DR. NORTON: May I make a motion from here? I would like, Mr. President, to move that Dr. Ulmer and as many members of his Reference Committee as possible appear before the meeting of the Board of Trustees immediately following this meeting of the House of Delegates.

ACTING PRESIDENT SCHAAF: The invitation will be duly issued.

(Dr. Ulmer read the portion of the report relating to the Board of Trustees.)

REPORT OF THE BOARD OF TRUSTEES

We have reviewed their report and approved it. We are pleased to note that the activities of their meetings are published in the JOURNAL, and they should so continue.

DR. ULMER (Continuing): Mr. President, I move the adoption of this portion of the report.

(The motion was regularly seconded, put to a vote and carried.)

DR. ULMER: The fourth and final item, sir.

(Dr. Ulmer read the portion of the report relating to the Judicial Council.)

REPORT OF THE JUDICIAL COUNCIL

We have reviewed the reports of the five Councilors. It is pleasing to note that no matters of an ethical or judicial character were brought to their attention during the year. It would appear that the county societies are functioning with harmony.

Respectfully submitted:

CHESTER I. ULMER, M.D.,
Chairman.

DR. ULMER (Continuing): I move, sir, the adoption of this portion of the report.

(The motion was regularly seconded, put to a vote and carried.)

ACTING PRESIDENT SCHAAF: Next is the report of Reference Committee "B", Dr. Murphy.

(Dr. Herschel S. Murphy, Roselle, read the first two paragraphs of the report of Reference Committee "B".)

REPORT OF REFERENCE COMMITTEE "B"

Reference Committee "B" met on April 22, 1947, considered the reports of the Treasurer, the Finance and Budget and Publication Committees and such other matters as were referred to it.

The report of the Treasurer was in full form as of April 15, 1947. The Committee approves the report and wishes to commend Dr. Young on his splendid work which he does quietly and so well.

DR. MURPHY (Continuing): Mr. President, I move the adoption of this section of the report.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Murphy read the third paragraph of the report.)

The report of the Finance and Budget Committee was carefully examined and discussed. The budget for 1947-48 a total of $82,770.00 was approved.

DR. MURPHY (Continuing): Mr. President, I move approval of this section of the report.

(The motion was regularly seconded.)

ACTING PRESIDENT SCHAAF: It is regularly moved and seconded that this portion of the report be adopted. Is there any discussion?

(The question was called for, and the motion was put to a vote and carried.)

Also, the following recommendations were considered at this time:

(Dr. Murphy read recommendation No. 1.)

1. The Board of Trustees approved the recommendation that all veteran medical officers who were members in good standing of The Medical Society of New Jersey at the time of entrance into military service be entitled to one full year's credit or remission of dues. Our Committee recommends the approval of this recommendation with a phrase added and the full recommendation would then read as follows: The Board of Trustees approved a recommendation that all veteran medical officers who were members in good standing of The Medical Society of New Jersey at the time of entrance into military service be entitled to one full year's credit or remission of dues in addition to remission of dues during the balance of the year during which he was discharged.

DR. MURPHY (Continuing): Mr. President, I move the approval of this particular recommendation with the addition.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Murphy read recommendation No. 2.)

2. The Essex County Medical Society recommended that The Medical Society of New Jersey remit the dues of those veteran members who are taking full-time graduate training under Public Law 346, and who are not in the private practice of medicine.

The Committee disapproves of this recommendation since we feel this will establish a very definite precedent quite different from our present policy and we feel that this should be left up to each county society to handle in the way they think best.

DR. MURPHY (Continuing): Mr. President, I move the adoption of this part of the report.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Murphy read recommendation No. 3.)

3. Our Committee considered the following recommendation of the Finance and Budget Committee: Recommendation of Finance and Budget Committee that dues for 1948 be $20.00 per member. Our Committee studied this problem and recommend that $20.00 be adopted as dues for the coming year. We wish to commend Dr. Allman and his Committee for their very excellent report and the work which they have done.

DR. MURPHY (Continuing): Before I move the adoption of this section, I might say that we knew that the members would like to have the dues lower; but with the necessary expenses this year, it would be unsafe to reduce them below $20. We had hoped that perhaps they might be $15, but that is not in our province. Perhaps next year something may be a little bit different with our finances and they may be such that that can then be considered.

Now, Mr. President, I move the adoption of this section of our report that our dues for the year be $20.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Murphy read the final paragraph of the report.)

The report of the Publication Committee was presented by Dr. Barkhorn and a copy appears in the JOURNAL of The Medical Society of New Jersey for April 1947. The standard of the Journal has been excellent and it is anticipated that there will be a profit to the Society from the publication of our JOURNAL this year. Dr. Davidson has done an excellent job both with his editorial and his general care in editing the Journal. We wish to commend Dr. Henry C. Barkhorn, the chairman of the Committee, as well as Dr. Henry A. Davidson, the editor. The report of the Publication Committee was approved.

DR. MURPHY (Continuing): Mr. President, I move the adoption of this section of the report.

(The motion was regularly seconded, put to a vote and carried.)

DR. MURPHY: Mr. President, I move the adoption of the report as a whole.

(The motion was regularly seconded, put to a vote and carried.)

ACTING PRESIDENT SCHAAF: We will now call for Reference Committee "C" to report; Dr. Johnsen, Chairman.

DR. SIGURD W. JOHNSEN (Passaic): Mr. President, Members of the House of Delegates, and guests: Reference Committee "C" met on Tuesday and considered and approved upon motion the published and supplemental reports of the following: Medical Service Administration, Medical-Surgical Plan, State Board of Medical Examiners, Military Service Committee, and Veterans Liaison Committee. The reports dealt with statistical matters, and the committee approved them in toto.

There was a supplemental report issued by the Veterans Liaison Committee which involved new procedures and new policies which, fortunately, were not the province of the Reference Committee. So, we boiled down three pages to two recommendations, with the concurrence of the Veterans Liaison Committee. These two provisions are already in operation, but it was felt that emphasis should be placed upon these two points in the renewal of the present contract with the Veterans Administration, which expires in June.

The recommendation was as follows:

That before the contract between the Medical Service Administration and the Veterans Administration is renewed in June, it shall be carefully reviewed and amended as necessary to assure (1) free choice and free choice only of physician by the veteran when not treated in a Veterans Administration installation and (2) that the contract be amended so as to assure the efficient and effective administration by our liaison officer.

I move, Mr. President, the adoption of the entire report.

(The motion was regularly seconded, put to a vote and carried.)

ACTING PRESIDENT SCHAAF: We will now ask Dr. Allman to report for Reference Committee "D".

DR. DAVID B. ALLMAN (Atlantic City): Mr. President and Members of the House of Delegates: Reference Committee "D" met on Tuesday. We consider first the report of the Postgraduate Education Committee. The chairman of that committee was present and submitted a supplementary report. We commend Dr. Decker and his committee for the fine work that they are doing. We approve of what they have done and what they plan to do.

I move the adoption of this portion of the report, Mr. President.

(The motion was regularly seconded, put to a vote and carried.)

DR. ALLMAN: The second committee report was that of the Scientific Work Committee. Their report was that this committee has been inactive during the past year. We could find nothing wrong with what they had not done, and therefore we move that that report be approved.

(The motion was regularly seconded, put to a vote and carried.)

DR. ALLMAN: The third committee report was that of Medical Defense and Insurance. We approve of this. The Committee are having some difficulties. They are doing fine work, and we feel that they should receive our support, congratulations, and approval of their report. I so move.

(The motion was regularly seconded, put to a vote and carried.)

DR. ALLMAN: The fourth report was that of the Advisory Committee to the Woman's Auxiliary, of which Dr. William E. Dodd is Chairman. We are extremely happy, in spite of the fact that Dr. Dodd was a member of the Reference Committee, to note the progress the women are making under Dr. Dodd's adviserships, and we are anxious to emphasize the fact that the Woman's Auxiliary is a potential force that has not been fully utilized in the past. Your committee feels that Dr. Dodd is making every effort fully to utilize it. We feel that he and his committee should be congratulated, and we move, sir, that the report of the Advisory Committee to the Woman's Auxiliary be accepted.

(The motion was regularly seconded, put to a vote and carried.)

DR. ALLMAN: Mr. President, I move that the report in toto be adopted.

(The question was called for, and the motion was put to a vote and carried.)

ACTING PRESIDENT SCHAAF: We will now have the report of Reference Committee "E", Dr. Barkhorn Chairman.

(Dr. Henry C. Barkhorn, Newark, read the first section of the report of Reference Committee "E", relating to the resolution from the Monmouth County Medical Society.)

REPORT OF REFERENCE COMMITTEE "E"

We carefully reviewed the source material for the resolution adopted by the Monmouth County Medical Society, and referred to us. We decided that this was a very important problem and we recommend: (1) that the House of Delegates direct the President to appoint a committee of seven to crystallize the mechanism of approach to the problem of providing good medical care for every citizen of New Jersey; (2) that the American Medical Association, the state and county societies fol-

low through on the newly created policies on public relations of the A. M. A.; (3) that we support the New Jersey Health Congress. We have gathered an amount of material which is on file in the Executive Offices in Trenton for future reference.

DR. BARKHORN (Continuing): I move the adoption of this portion of the report.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Barkhorn read the section of the report relating to fees from insurance companies.)

We next considered the resolution on fees from insurance companies (Tennessee Plan) and recommend that the fee for life insurance examinations be raised to $10, with all other medical insurance fees to be increased in like proportion; a copy of this resolution to be sent to:

Equitable Life Insurance Co., New York.
Metropolitan Life Insurance Co., New York.
The Penn Mutual Life Insurance Co., Philadelphia, Pa.
The Connecticut Mutual Life Insurance Co., Hartford, Conn.
Massachusetts Mutual, Springfield, Mass.
Prudential Life Insurance Co., Newark, N. J.
John Hancock, Boston, Mass.
Mutual Benefit Life Insurance Co., Newark, N. J.

DR. BARKHORN (Continuing): I move the adoption of this portion of the report.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Barkhorn read the section of the report relating to compensation fees.)

Our last resolution was on compensation fees. Agreeing with the report of Dr. William K. Harryman, Chairman of the Advisory Committee on Workmen's Compensation, we recommend that this be solved on the county unit basis by the various county Workmen's Compensation Committees.

DR. BARKHORN (Continuing): Mr. President, I move the adoption of this portion of the report.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Barkhorn read paragraphs 1 and 2 of the report.)

SUBCOMMITTEE ON LEGISLATION

We commend the Subcommittee on Legislation—its chairman; its executive secretary; Dr. Samuel Alexander, its Trustee adviser; and all its members for a perfect coverage of both the federal and the state fields.

Concerning the Taft-Smith-Ball-Donnell bill, we realize that most phases agree with our concepts, but we strongly urge that several representatives, perhaps including the president, be sent to the hearings in Washington.

DR. BARKHORN: Mr. Chairman, I move the adoption of this portion of the report.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Barkhorn read paragraph 3 of the report.)

The Taft-Fulbright bill does not agree with the aims of organized medicine; we thoroughly disapprove, and strongly urge that Senators Taft and Fulbright be so informed.

DR. BARKHORN: Mr. President, I move the adoption of this portion of the report.

(The motion was regularly seconded, put to a vote and carried.)

DR. BARKHORN: Mr. President, I move the adoption and approval of both the report and the supplementary report of the Subcommittee on Legislation.

(The motion was regularly seconded, put to a vote and carried.)

(Dr. Barkhorn read the remainder of the report.)

PUBLIC RELATIONS

We strongly urge that continued efforts be made to evolve a speakers' bureau in spite of certain discouraging aspects, and agree that whenever we get an executive officer he should be designated *ex-officio* Executive Secretary of the Subcommittee on Public Relations.

PUBLIC HEALTH

We commend this committee for stressing again the importance of members of the medical profession of New Jersey assuming the responsibility for, and manifesting an active leadership in, public health in the state irrespective of what form it may take.

CANCER CONTROL

This Committee has shown magnificent initiative and energy in carrying on its work in this important medical field with its tremendous popular appeal. We assure them of the support of the Society, and that the Publication Committee is at their service for all publicity.

CHILD HEALTH

We concur in their five-point program: (1) an improved school health program; (2) a program for the improvement of neonatal mortality; (3) rheumatic heart disease control (this is the greatest single cause of death in school children, except accidents); (4) A good

mental hygiene program for children; and (5) better medical care for children in low income families.

COMMITTEE ON CONSERVATION OF VISION AND HEARING

We recommend that this committee continue its efforts in limiting the activities of certain optometrists in prescribing glasses for school children.

MATERNAL WELFARE

We recommend continuation of its four-point program: (1) to continue efforts to maintain a high standard of obstetrical practice in New Jersey, aiming particularly to eliminate preventable maternal deaths; (2) to study obstetrical responsibility for the persistently high rate of neonatal deaths, and join with the Child Health Committee in efforts to reduce this rate; (3) to consider the problem presented by new "hospitals" which are often privately owned institutions offering maternity care of unknown quality without check or supervision; and (4) to aid in providing facilities for much needed postgraduate training in obstetrics.

MENTAL HYGIENE

We recommend continuation of its five-point program: (1) education of the public; (2) education of the medical profession; (3) medical leadership; (4) alcoholics; and (5) psychiatric and mental hygiene services in general hospitals.

We emphasize that it would be wise to place a psychiatrist at the disposal of each county superintendent of schools or of such groups of county superintendents of schools, as would be adequate to meet the needs of these populations.

NUTRITION

This committee has sincerely endeavored to take nutrition out of the hands of faddists and radio commentators. We recommend that this activity be continued.

SCHOOL HEALTH

We commend their five-point program: (1) strip to the waist examinations; (2) complete examinations on admission, the 4th grade, the 8th grade and the 12th grade, with the parent present whenever possible; (3) each county superintendent should be required to add a psychiatrist to the school system; (4) compulsory vaccination against smallpox and immunization against diphtheria, with a recent negative Schick Test; and (5) all school teachers and adult school personnel should be x-rayed for tuberculosis every year. We recommend that this program be continued.

TUBERCULOSIS

We commend their seven-point program: (1) x-raying all hospital admissions and clinic cases routinely *when feasible;* (2) organization of community surveys; (3) importance of "contagious technic" in mental and general hospitals; (4) central registry; (5) routine tuberculin testing in schools; (6) x-raying all school children; and (7) annual radiologic surveys in schools for personnel as well as for students.

VENEREAL DISEASE

This committee has evolved an excellent program. We recommend that they study carefully the problem of teaching sex hygiene and do not by any tactless approach antagonize any group of parents in our communities. However, we have confidence in their common sense and are sure they will solve this problem to the satisfaction of all.

HOSPITALS

We agree that there should be more medical members on the Boards of Trustees of the various hospitals and that internship standards should be raised as rapidly as possible throughout New Jersey so that our graduates may equal those of hospitals connected with teaching institutions.

INDUSTRIAL HEALTH

We urge this committee to continue its participation in the projects of the American Academy of Occupational Medicine.

LABORATORY MEDICINE

We urge this committee to continue its activities and assure them of cooperation of all committees of The Medical Society of New Jersey.

NURSING AND NURSING EDUCATION

We urge this committee to continue its cooperation in formulating the standards of the proposed revision of the New Jersey Nurses Practice Act.

PHARMACEUTICAL PROBLEMS

We recommend that this committee be authorized to publish a fifth edition of the New Jersey *Formulary,* if this has not already been done.

PHYSICAL MEDICINE

We agree with this committee that departments of physical medicine should be under

the direction of a physician trained in physiotherapy.

WORKMEN'S COMPENSATION

We urge this committee to publish its revised *Suggestions for the General Practitioner,* and agree that fee bases should be established on a county level by county Workmen's Compensation committees.

DR. BARKHORN: Mr. Chairman, I move the approval of the report as a whole.

(The motion was regularly seconded, put to a vote and carried.)

ACTING PRESIDENT SCHAAF: Next, the Reference Committee on Miscellaneous Business, Dr. Green, Chairman.

(Dr. David W. Green, Salem, read the first paragraph of the report of the Reference Committee on Miscellaneous Business.)

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Your Committee considered and approved the reports of the Annual Meeting Committee and the Subcommittee on Scientific Program. We commend the Committee for bringing this meeting to Haddon Hall and compliment them on the excellent program offered and for securing so many exhibits.

DR. GREEN (Continuing): I move the adoption of that portion of the report.

(The motion was regularly seconded, put to a vote and carried.)

The recommendation for renewal of the Fall Clinical Conference was considered and approved, and we suggest that Bergen and Passaic Counties be responsible for this meeting. We also recommend that the lecture on the last night be called the Elias J. Marsh Oration.

DR. GREEN (Continuing): I move the approval of that section of the report.

(The motion was regularly seconded, put to a vote and carried.)

Your Reference Committee also recommends that the 1948 Annual Meeting be held in Atlantic City at Haddon Hall in May or the last week in April, the exact time to be determined by the Board of Trustees.

DR. GREEN (Continuing): I move the adoption of that portion of the report.

(The motion was regularly seconded, put to a vote and carried.)

DR. GREEN: The members and delegates of the Medical Society are urged to register with the exhibitors. These exhibitors pay for your convention, and due consideration should be shown them. Unless there is better registration at the booths, the financial success mentioned will be jeopardized.

I move the adoption of this report as a whole.

(The motion was regularly seconded, put to a vote and carried.)

ACTING PRESIDENT SCHAAF: We will ask the Secretary to make the report for Dr. Crowe with reference to the Committee on Credentials.

DR. ALFRED STAHL (Secretary, Newark): Seven hundred seventy-five physicians have registered, of whom 235 are delegates. The total number of registrations is 1375, a very desirable and congratulatory amount.

ACTING PRESIDENT SCHAAF: With the adjournment of this session of the House of Delegates, we will lose our Secretary, Dr. Stahl, who has served the Society faithfully for ten years. In recognition of his contribution to the welfare of the Society, the Board of Trustees passed a resolution at its meeting Monday night, which has been published, in which it cites Dr. Stahl's services, commends him and thanks him for all that he has done.

In addition to the passage of this resolution, the Board of Trustees authorized the issuance of a Society Key to Dr. Stahl, engraved, "Secretary, 1937-1947". Dr. Stahl, on behalf of The Medical Society of New Jersey, it is my very great privilege to present you with the Key of the Society, together with our thanks.

(The audience arose and applauded.)

DR. STAHL: I thank you for this token of appreciation. I assure you it has been a labor of love the last ten years. I have enjoyed it, and I hope I haven't been too disappointing to the House of Delegates.

ACTING PRESIDENT SCHAAF: There is no more business, finished or unfinished, to be taken up at this time, so I shall ask Dr. Scammell if he would like to say a word of farewell to this House of Delegates.

PRESIDENT SCAMMELL: Dr. Schaaf and Delegates to the 181st Annual Meeting: It is rather difficult to enumerate the many conditions which we as physicians are brought up against, but I want to take this one opportunity of paying my respects to the Keymen and the men who served on the committees during the past year, who have made it so pleasant for me and my esteemed friend, the President-Elect, who has conducted meetings of several different kinds, so that the meetings of the Society all over the State have been amicably carried on without any divergencies.

It seems to me that this meeting has been rather severe in a way and that really its closing should be carried on in somewhat a loquacious vein. So, I would ask you to bear with me for a minute while I read this little poem which may be of some value to you—not to me, because in the last few months I have been a prescribed aspirant, not a very dutiful member, of the White Ribbon Society. I thought perhaps it might not be out of place if I read this to you and gave you perhaps an inkling of how you might live for perhaps a little longer than the ordinary time. It reads like this:

The horse and mule live thirty years
And nothing know of wine and beers,
The goat and sheep at twenty die
And never taste of Scotch and rye,
The cow drinks water by the ton
And at eighteen is mostly done,
The dog at fifteen cashes in
Without the aid of rum or gin,
The cat in milk and water soaks
And then in twelve short years it floats,
The modest, sober, bone-dry hen
Lays eggs for nogs, and then dies at ten;
All animals are strictly dry,
They sinless live and swiftly die,
But sinful, gin-full, rum-soaked men
Survive for threescore years and ten,
And some of us, the mighty few,
Stay pickled 'til we're ninety-two.

(Laughter)

I am somewhat mindful of Bill Hughes, who had a clinic one morning on the effects on the nervous system from the use of alcohol, a clinic which was devoted to acute alcoholism. All his talk on that was lost on me, with the exception of the place where he said that he thought that a doctor or a man—I think he mentioned a doctor—was a fool if he drank before fifty and was a fool if he didn't drink after fifty.

This brings to a conclusion a very wonderful epoch in my life. Fortunately, I have been surrounded by the finest friends I think any man ever had. It was my friends that made me the president of my county society, to which every man aspires when he is a member of his county society. I don't want you to think that I am bigoted or that I have to go collegiate all the time and not wear a hat, because I am going to wear a hat, and I hope the same size, but it was my friends that made me the President of the New Jersey State Surgical Society. Then, as you know, through the accumulation of the years and the numbers of friends that I had made, I was placed in the ascendancy to what I think is the acme of the profession in this or any state, being made the President of The Medical Society of New Jersey. I am deeply affected by the manner in which my friends have stood by me, and I hope, with God's assistance, that I shall always be able to stick by my friends.

At this time I shall say my adieu with reference to the presidency of this honorable body, and in leaving it I will say that I could have no better successor, no matter who he is, than our able President-Elect, Dr. Schaaf, on whose shoulders the mantle of The Medical Society of New Jersey now rests.

(The audience arose and applauded.)

PRESIDENT SCHAAF: Dr. Scammel, Members of the House of Delegates, and Guests: It is a great honor to become President of the Society, and I will make my inaugural address exceedingly brief.

The presidency of The Medical Society of New Jersey carries with it great honor and distinction, but also exacting obligations of which I am fully aware. I deeply appreciate the opportunity which you have given me to serve this Society, and I shall exert every effort to discharge the duties of my new office diligently and faithfully.

The year ahead promises to be a very busy one. All of our long-term activities will be continued, but special attention must be devoted to certain phases of our work, including medical care of the veteran, public relations, legislation, public health, distribution of medical care, cancer, corporate practice of medicine by hospitals, graduate and undergraduate medical education, and so forth. A lengthy paragraph could be devoted to each of these as well as many other topics, but since time will not permit of an adequate discussion of any of them at this meeting, I shall cover them by presidential messages to be published from time to time in our JOURNAL.

The committee assignments have been made, and we are ready to proceed with our work without the interruption which is so prone to occur when administrations change. For the most part, the committees are composed of members who are experienced in their special committee work, and the committees can be counted upon to function as smoothly and efficiently as they have in the past. There is much work to be done and many projects to be undertaken. I am confident that I can depend upon the continued loyalty and cooperation of every member of the Society, and with the assurance of your support, I shall enter upon my new duties with energy and enthusiasm and with the hope that at the end of my term of office, you will say that the affairs of the Society have been efficiently and expeditiously managed.

I thank you.

The meeting will stand adjourned *sine die*.

(The meeting adjourned at three-five o'clock.)

ANNUAL DINNER

Wednesday Evening, April 23, 1947

The dinner in honor of Dr. Frank G. Scammell, President of the Society, given by the Woman's Auxiliary, convened at eight o'clock, President Scammell presiding.

President Scammell: I have asked Colonel Walton to say grace for us.

Colonel George Walton (Haddonfield): Our Lord God, we remember that all good things come from you. Though we take the wings of the morning and dwell on the uttermost part of the seas, Thou art with us, and Thy right hand is upon us. Amen.

(Following dinner, the speaking began at nine-thirty.)

President Scammell: We are going to minimize all our introductions as much as we can. It is very gratifying to see so many here. I am especially proud myself of my Mercer County friends.

It is hard for me to introduce the next speaker because I think she feels very badly because of the fact that she is on the out. Of course, she has company, because I am right with her. I am going out, too. It gives me great pleasure to bring before you the President of the Woman's Auxiliary for this last year, Mrs. Wandall.

Mrs. Frederick G. Wandall (President, Woman's Auxiliary to The Medical Society of New Jersey): It is an honor to extend greetings to our Governor, the Honorable and Mrs. Alfred E. Driscoll, to our President, Dr. Frank G. Scammell, and to our honored guests and our friends, the doctors, in the name of the Woman's Auxiliary of The Medical Society of New Jersey.

It has been a privilege in the past year, as it has been in the years before, to serve our Medical Society. We shall look forward to new horizons of accomplishment and endeavor to continue to merit the continued confidence of our Medical Society. I thank you.

President Scammell: It is a wonderful thing for me now to introduce this gentleman. I want to tell you, he is one of the most versatile men in handling business of all types, and he does it with such discretion and dispatch that it really looks as if I had had something to do with it; but I am going to be perfectly honest and say that I didn't, that it was through his efforts and the efforts of the men who served so faithfully on the different committees. Fortunately for me, I received a great deal of the praise. It is a wonderful opportunity for me, and I am sure I would do it over and over and over again if it were necessary. It is my pleasure to introduce my right-hand kicker, who certainly carried it on wonderfully for me while I was ill, the President-Elect, Dr. Schaaf, who will go into office tomorrow. Dr. Schaaf. (Applause.)

Dr. Royal A. Schaaf (President-Elect, The Medical Society of New Jersey): Dr. Scammell, Mrs. Wandall, Honored Guests, Ladies and Gentlemen: It is a great honor and privilege to be elected President of the Society, but it is not my intention to make an address. I wish to express to Mrs. Wandall and to the ladies of the Auxiliary my profound thanks for this wonderful evening and for the work they have done the past year. It has been a great pleasure to serve with Dr. Scammell. There is no one I would rather have served than Dr. Scammell.

It has been traditional for many years to present the Fellowship Key to the retiring President on the occasion of the annual dinner. I shall therefore ask Dr. Alexander, who has the honor and privilege of presenting the Key, to come forward. Dr. Alexander.

Dr. Samuel Alexander (Park Ridge): Dr. Schaaf, Dr. Scammell, Mrs. Wandall, Governor and Mrs. Driscoll, Ladies and Gentlemen: For many years it has been the custom to present the retiring President with a key. This symbol is an indication of the work and effort of the retiring President of the Society during the past year. As the Junior Past President of this Society, it is a privilege and pleasure to present to you, Dr. Scammell, this key.

President Scammell: Dr. Alexander and Friends: It is pretty hard to say anything now because I am somewhat sympathetic. They say that the Welsh are more sympathetic than any other, perhaps. My father and mother were both Welsh. So, I am going just to say thank you, because that is all I can say.

Our next honored guest comes from a section of the State which we hold in high esteem. I was told today, "You go in the Woman's Auxiliary, and you will meet a very excellent looking woman and, if you converse with her, she is a very bright woman. Almost anybody can tell you who she is." I want to take this opportunity to show you—not introduce to you, but show you—who is the next President of the Woman's Auxiliary. Mrs. Lodovico Mancusi-Ungaro, President-Elect.

It is very difficult to make an introduction

for the next person on our program for the simple reason that I have known him quite a while and I can't say anything bad about him. It is easier to make bad talk about a person than it is to say all the good you can about him.

A few years ago when my daughter was married, one of my patients said to me, "Doctor, where is your daughter going to live?" I said, "In Haddonfield." He said, "That is a very nice town, but I hope they use her better than they do me." I said, "Well, what's the trouble? I didn't know that you had any ties on Haddonfield." He said, "I have quite a number of bonds, and they don't pay any interest." I said, "I think you have a right to kick."

Sometime later there were other people in that area who must have thought some of the things that I thought, because there was a group of the younger citizens in the town who banded themselves together and formed the Clean Government League. They canvassed the town, and when it had been thoroughly canvassed, which was before the next election, they elected a new commission. One of the commissioners was a gentleman whom I had not known very much before. But I made careful inquiry and found that he would make an excellent commissioner. He was made commissioner of finance. Due to his intense interest and his application to the position that he had, to show you how zealously he worked, they paid off over a million dollars' worth of the debt in Haddonfield and their bonds are now 3-A.

This couldn't be placed under a basket. The light that that gentleman had couldn't be shadowed. So, he was nominated for state senator and, running true to form, on an honest basis, he was elected to the Senate of New Jersey and filled that office with such credit that when it was necesssary for them to appoint an Alcoholic Beverage Control Commissioner, he was the first man thought of. Any man who can go through a position where he has to hobnob (with no disrespect meant) with the people who sell whiskey and beer is often in jeopardy of a smirch on his character which will hurt him forever afterwards. But they couldn't do it to this friend of mine.

So, I became more thoroughly entrenched in my liking for this gentleman.

A little later on there was a controversy over who should be the nominee for Governor of New Jersey on the Republican ticket. There were two aspirants. One was a seasoned campaigner and a wonderful entertainer. The other was our guest tonight.

When the campaign started for this nomination, I was asked if I would be the treasurer in this gentleman's campaign for Mercer County, and I said, "There is nothing that would give me more pleasure than to work for a man who is as straight-forward and honest as this man is, because I feel that I don't have to make any apologies. That is the kind of people I like to work for."

Well, we gave him a big majority in Mercer County. And when it came time for the people of New Jersey to vote on this gentleman, it brought to my mind that it had taken one hundred and two years for the people in Camden County to recognize the fact that they had a man of superior ability and wonderful accomplishments who could fill the governor's chair. It was hard to make them believe that we had that, because there are a lot of men who have come from Camden and have filled offices in New Jersey in all walks of life and who have been a decided credit to it; but it took them one hundred and two years to find out that they were going to have a governor from Camden County.

I want to tell you that I am happy to say that there he is—Mr. Driscoll, the Governor of New Jersey.

THE HONORABLE ALFRED E. DRISCOLL (Governor of the State of New Jersey): Dr. Scammell, Ladies and Gentlemen: May I quickly add that I was not in Camden County the entire one hundred and two years, lest there be any misunderstanding on that score.

It is perfectly apparent that I am here this evening because of the great affection that I have for your President. My affection stems not from the fact that he did decide once again to enter the political arena, but rather from the fact that in your President you have not only a good physician but an excellent citizen.

I am here this evening also because I count it a personal privilege, as the Governor of the State, to underscore the professional point of view. In 1947 in New Jersey and in these United States and in this world of ours, we need as never before the professional point of view. (Applause.)

We need it for many reasons. Against the babel of voices, the clamor of many tongues, the dissension in Moscow, we must project, if we are to succeed in our ambition to avoid war, the integrity that accompanies the professional point of view, because the very essence of the professional point of view is integrity. A doctor, a lawyer, an engineer, a businessman, who lacks integrity cannot have and never will have the professional point of view. We need integrity in the business of government; we need

the professional point of view in the business of government.

You folks, by your daily activities in the large and small communities of our state, by your acceptance of your professional responsibility and by your participation in community affairs, can help us hold fast to something that has been gradually slipping away, which I think is so terribly important in this world of ours.

There was a time when the doctor, the lawyer, and the village minister or priest were the leaders of society. They were leaders because they were trained men and trained women. They were leaders because folks looked up to them as men and women with broad experience, with trained, disciplined background. But gradually over a period of years their prominence in civic affairs has been somewhat lost, and in that loss the whole country has shared.

Here in New Jersey we are about to make a new start. I am hopeful that in June the citizens of this state will direct the convening of a constitutional convention in the historic city of New Brunswick at old Queen's college, presently the state university, Rutgers. More immediately, it will be part of my task as your Governor to select the best men and women available in this state for the new Health Council. I tell you frankly that I intend to come to your officers for advice and counsel and, knowing your officers, I will expect their advice to be extremely helpful to me in the organization of a Health Council second to none in this nation of ours. We will want on that Council the professional point of view. We will expect that Council to become an important part of our business of government, because New Jersey is a tremendously active industrial state and, as an industrial state, we should have a Health Council second to none just as we should have a Department of Health second to none in the land.

You are part of our board of directors; you are part of our stockholders in this state. We have high hopes that, with the reorganization of the Department of Health provided for in the recent legislation that was adopted at the last session, we can go forward, without any criticism of the Department's activities in the past—and none is implied by my statement—with new projects designed not to promote socialized medicine but, on the contrary, to promote sound public health.

I consistently oppose socialized medicine at all levels of government. I have an abiding fear of big government. One of the great struggles that your present administration is engaged in is with those who believe that all government must stem from Washington, be it in the field of public health, labor relations, taxation, or what have you. I am extremely hopeful that during the next three years we can demonstrate that our states may be and should be the administrative agencies for much of the business of government, that we can adopt an over-all program for government in this country of ours which will permit at the state level the maximum amount of activity.

If we are to accomplish that great project, it means that those of us who are interested in social reform must see to it that the states lead in those social reforms.

Speaking this afternoon at a forum with the challenging title, "One World, Now or Never," I was amazed to hear a speaker say that in his judgment, because the states had failed in the past to meet their obligations, there was no particular point in giving new duties and new responsibilities to the states, that the federal government would have to take over the great task of educating our youth, that the federal government would have to take over the tremendous responsibility of protecting our public health.

I differ with that speaker. I believe that the states are fully capable of assuming new responsibilities, that our citizens should be ever mindful of the need for administrative responsibility at the state level.

Recently in New Jersey we have been debating this great question of sickness benefit payments, which some people refer to as "cash sickness," a rather inappropriate title. I am convinced that under the formula that was submitted to the Legislature at the last session, we can achieve that great social reform without in any manner jeopardizing private enterprise and the professional point of view, and at the same time guard against the great economic loss that almost always accompanies prolonged illness on the part of the men and women who staff our great industries and our offices.

Sometime I hope to have the opportunity to meet with you informally and to discuss that particularly interesting problem, but for the moment suffice it to say that, as good citizens, we must be thinking in terms, on the one hand, of maintaining the professional point of view, private enterprise, and, on the other hand, of going forward with those reforms that are so badly needed to protect our society against the very ills that our industrial genius and our ability to invent machines have brought upon us in many instances.

Dr. Scammell, I am happy that it was pos-

sible for me to be with you and your friends on this great occasion. I am happy to say to you that the whole state respects you and respects the office which you have held. The whole state is glad that we have the fine men and women who make up our Medical Society. Your welfare is our welfare. Your interest is the welfare of our citizens. Your service is a great service to the state, to all of its citizens. I am happy that I was invited this evening and that I could be here.

I thank you.

President Scammell: I still believe that my judgment has not been misplaced. I really should say more about him and Mrs. Driscoll and the rest of them, but there has to be a cessation of festivities along certain lines in order that you may get to your rooms or to your homes. So this concludes this portion of our evening, and brings to an end our panorama of guests. I take that opportunity to say thank you very much for all you have done. Now we will have the entertainment.

(The program of music and dancing followed.)

TRANSACTIONS OF THE WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

I. PRECONVENTION BOARD MEETING

The preconvention Board Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held at Haddon Hall, Atlantic City, April 22, 1947. The meeting was called to order by the president, Mrs. Frederick G. Wandall. After roll call, minutes of the March meeting were read and approved. The treasurer, Mrs. T. J. McConaghy submitted a statement showing a balance in the treasury of $796.61. This report was received for audit.

CORRESPONDENCE

Mrs. Chester I. Ulmer, the corresponding secretary, read the following communications:

A letter from Mrs. Don A. Epler thanking us for the message and flowers sent to her.

A letter from the New Jersey Milk Official Grades Association inviting Mrs. Wandall to be a guest at luncheon on April 30.

A letter from Mrs. Jesse Hamer, national auxiliary president, thanking us for inviting her to attend our Annual Meeting and stating that she could not attend because of previous arrangements.

REPORT OF THE PRESIDENT

Mrs. Andrew C. Ruoff, first vice-president, was asked to take the chair during the presentation of the president's report. Mrs. G. E. McDonnel moved that the report of the president be accepted with thanks. This was seconded by Mrs. McConaghy and carried.

REPORTS OF COMMITTEE CHAIRMEN

Mrs. William E. Dodd moved that the reports of standing committees be accepted as a whole upon completion of their readings. This was seconded by Mrs. Sherk.

Reports were submitted by the following committee chairmen:

Medical History	Mrs. S. H. Jessurun
Bulletin	Filed
Finance	Mrs. G. E. McDonnel
Historian	Filed
Hygeia	Mrs. Edward A. Murphy
Legislation	Mrs. Joseph E. Mott
Credentials	Mrs. Daniel C. Reyner
Organization	Mrs. O. R. Carlander
Press and Publicity	Mrs. R. B. Walker
Public Relations	Mrs. Thomas H. McGlade
Revisions	Mrs. Andrew C. Ruoff

The pending motion to accept these reports as a whole upon completion of their readings was carried.

REPORTS OF COUNTY PRESIDENTS

Mrs. Joseph E. Mott moved that the reports of county presidents be accepted as a whole upon completion of their readings. This was seconded by Mrs. Ruoff.

Reports were submitted by the following county presidents:

Atlantic	Mrs. Charles Hyman
Burlington	Mrs. A. Ziccardi
Camden	Mrs. A. Lincoln Sherk
Essex	Mrs. Frank S. Forte
Gloucester	Mrs. C. A. Bowersox
Hudson	Mrs. E. A. Murphy
Middlesex	Mrs. R. B. Walker
Passaic	Mrs. A. G. Markel
Warren	Mrs. Homer Bloom

The pending motion to accept these reports as a whole upon completion of their readings was carried.

AUDITING COMMITTEE

Mrs. Wandall appointed the following members to serve on the auditing committee: Mrs. Chester I. Ulmer, Mrs. Banks S. Baker, and Mrs. G. E. McDonnel, Chairman.

ANNOUNCEMENTS

Mrs. Wandall announced that Mrs. Hornberger had been very ill in the Burlington County Hospital in Mt. Holly, and that Dr. Floyd A. Shimer has also been ill.

Mrs. McConaghy moved that we send flowers to Mrs. Hornberger. This was seconded by Mrs. Yaguda and carried.

Mrs. Allman, convention chairman, urged all members to make reservations for luncheon and dinner in order that plans might be made with the hotel. Mrs. Allman also called attention to the tea to which all doctors' wives are invited.

Mrs. G. E. McDonnel requested that all bills be handed in today in order that the books may be audited.

There being no further business the meeting adjourned.

Respectfully submitted,

MRS. BANKS S. BAKER,
Recording Secretary.

II. TWENTIETH ANNUAL MEETING

The Twentieth Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held at Haddon Hall, Atlantic City, on April 23, 1947. The meeting was called to order by Mrs. Wandall, the president. The invocation was given by the Reverend Arthur J. Blythe of Atlantic City. On motion made by Mrs. A. L. Sherk, and seconded by Mrs. H. R. Van Ness, the convention program, as printed, was approved.

The address of welcome was made by Mrs. Charles Hyman, president of the Woman's Auxiliary to the Atlantic County Medical Society, and an appropriate response was delivered by Mrs. Lodovico Mancusi-Ungaro, president-elect of the state auxiliary.

Memorial services were conducted by Mrs. Oswald R. Carlander, for two deceased members, Mrs. John Maher of Monmouth County and Mrs. William Pratt of Camden County.

The parliamentarian, Mrs. Asher Yaguda, read the *Rules and Procedure for the Convention,* and on motion of Mrs. Carlander, these were adopted. On motion made by Mrs. Van Ness, and seconded by Mrs. Merrill, the minutes of the Nineteenth Annual Meeting as printed in the 1946 TRANSACTIONS were approved as published.

The credentials chairman, Mrs. Daniel C. Reyner, presented an initial report indicating preliminary registration of 129 members. The treasurer, Mrs. T. P. McConaghy submitted both a regular financial report and a supplementary report covering the period since April 22. Mrs. G. E. McDonnel, chairman of the auditing committee, reported that Mrs. McConaghy's books had been examined and found correct. On motion made by Mrs. A. L. Sherk, the reports of the treasurer, and the attestation of the auditors were approved and adopted.

While the first vice-president, Mrs. Andrew C. Ruoff, took the chair, Mrs. Wandall delivered her final report (see page 41, these TRANSACTIONS). On motion made by Mrs. McConaghy, seconded by Mrs. McDonnel, this report was accepted with thanks.

The president introduced Dr. William E. Dodd, our Adviser, and also officials from two sister auxiliaries, Mrs. H. F. Pohlmann, president-elect of the New York State Auxiliary, and Mrs. George McIlfatrick, president of the Delaware Auxiliary.

Reports were submitted by the following officers: Mrs. L. Mancusi-Ungaro (president-elect), Mrs. Andrew C. Ruoff (first vice-president), Mrs. Banks S. Baker (recording secretary, Mrs. Chester Ulmer(corresponding secretary), and Mrs. O. R. Carlander (for the Advisory Board) as well as from two of the directors, Mrs. Robert B. Walker and Mrs. S. H. Jessurun.

On motion of Mrs. Frank S. Forte, seconded by Mrs. Albert G. Markel, these reports were accepted with thanks.

Reports were then submitted by the following committee chairmen:

Medical History	Mrs. S. H. Jessurun
Finance	Mrs. G. E. McDonnel
Historian	Mrs. R. J. Cottone
Hygeia	Mrs. E. A. Murphy
Legislation	Mrs. Joseph E. Mott
Organization	Mrs. O. R. Carlander
Press and Publicity	Mrs. Robert B. Walker
Program	Mrs. C. C. Chianese
Public Relations	Mrs. Thomas H. McGlade
Revisions	Mrs. Andrew C. Ruoff
Widows and Orphans	Mrs. Charles F. Merrill

Reports were also read on behalf of the chairmen of the archives committee and the bulletin committee. On motion of Mrs. E. A. Murphy, seconded by Mrs. S. H. Jessurun, these reports were accepted with appreciation. A special report of the safety committee was read by Mrs. Frank S. Forte, and on motion of Mrs. Mott, seconded by Mrs. Merrill, this was accepted. After a word of thanks for the committee's work, Mrs. Wandall discharged the committee.

Reports were then submitted by presidents of the following county auxiliaries:

Atlantic	Mrs. Charles Hyman
Burlington	Mrs. Anthony V. Ziccardi
Camden	Mrs. A. Lincoln Sherk
Essex	Mrs. Frank S. Forte
Gloucester	Mrs. Clarence A. Bowersox
Hudson	Mrs. E. A. Murphy
Mercer	Mrs. E. F. Purcell
Middlesex	Mrs. R. B. Walker
Monmouth	Mrs. Norman Nathanson
Ocean	Mrs. Carl Menge
Passaic	Mrs. Albert G. Markel
Union	Mrs. E. M. Staub
Warren	Mrs. Homer Bloom

On motion of Mrs. Thomas K. Lewis, seconded by Mrs. H. R. Van Ness, the reports of the county presidents were accepted.

Mrs. Wandall introduced Mrs. A. Haines Lippincott, State Commander of the Society for the Control of Cancer in New Jersey, and Mrs. Thomas P. McConaghy, our retiring treasurer, then she presented her with a corsage.

The meeting recessed for luncheon. Mrs. A. Haines Lippincott, First State President, acted as toastmistress. Guests were Dr. Frank G. Scammell, President of The Medical Society of New Jersey, and Dr. Frank F. Borzell, Vice-Speaker of the House of Delegates of the American Medical Association.

The meeting re-convened at 3:40 p. m.

Mrs. Daniel C. Reyner, Credentials Chairman, submitted an intermediate report showing a total of 202 members registered.

NEW BUSINESS

The recording secretary read the following proposed revisions to the By-Laws of the Woman's Auxiliary to the American Medical Association:

Chapter II, Section 2: At the end of the second sentence add the following: "at a meeting called for this purpose by the Constitutional Secretary, or in the event of her absence, by the President immediately following the meeting at which the Nominating Committee was elected". Between this sentence and the next insert the following sentence: "The election of the chairman shall be by ballot".

Mrs. McDonnel moved that our delegates and alternates be instructed to vote in the affirmative on this revision. This was seconded by Mrs. Santora and carried.

Chapter III, Section 2: Between the third and fourth sentences insert the following sentence: "She shall act as temporary chairman of the Nominating Committee as provided in Chapter II, Section 2, (a) of these By-Laws". Also add this sentence to Section 5.

Mrs. Carlander moved that our delegates and alternates be instructed to vote in the affirmative on this revision. This was seconded by Mrs. Jessurun and carried.

Chapter IV, Section 4: Add (d) as follows: "The chairman of the Finance Committee, or some member designated by her, shall report to the Board of Directors at each regular meeting of the Board."

Mrs. Dodd moved that our delegates and alternates be instructed to vote in the affirmative on this revision. This was seconded by Mrs. McConaghy and carried.

Chapter X Policy: Add Section 3 as follows: "All circular letters must be approved by the Board of Directors and the Advisory Council; provided, however, that the officers and the Executive Secretary of this Auxiliary may issue such circular letters as are considered necessary in the performance of their official duties".

Mrs. Dodd moved that our delegates and alternates be instructed to vote in the affirmative on this revision. This was seconded by Mrs. Allman and carried.

ELECTION OF NOMINATING COMMITTEE

Mrs. Asher Yaguda, the Parliamentarian, read Chapter I, Section 1 of the Auxiliary Constitution.

The following members were nominated to serve on the Nominating Committee, of which Mrs. Frederick G. Wandall, will be chairman:

Mrs. Thomas H. McGlade
Mrs. Frank Bien
Mrs. Vernon Davis
Mrs. R. J. McDonald

Mrs. Yaguda moved that these members be elected to the Nominating Committee. This was seconded by Mrs. McDonnel and unanimously carried. The president declared these members duly elected.

ELECTION OF OFFICERS

Mrs. William E. Dodd, Chairman of the Nominating Committee, submitted the following candidates for election:

President-elect, Mrs. Robert B. Walker
First vice-president, Mrs. C. C. Chianese
Second vice-president, Mrs. Thomas P. McConaghy
Recording secretary, Mrs. Banks S. Baker
Treasurer, Mrs. G. E. McDonnel
Directors, Mrs. S. H. Jessurun
Mrs. Norman Nathanson

Mrs. McDonnel moved that the recording secretary cast the unanimous ballot of the convention for these candidates. This motion was seconded by Mrs. Dodd and carried.

The President declared these candidates duly elected.

RESOLUTIONS

Mrs. R. J. Faulkingham, chairman of the committee on resolutions presented the following:

Be it resolved, that appreciation for the careful handling of all the details pertaining to the Convention, be extended to Mrs. David B. Allman, General Chairman of the Convention, and to her committee.

Be it further resolved, that appreciation be extended to the county hostess for the many courtesies shown in making this one of the most enjoyable and successful conventions attended by our society.

Be it further resolved, that Mr. Phillip E. Parlett, General Manager of the Haddon-Hall, be extended our appreciation for making our stay an enjoyable occasion.

Be it further resolved, that deep appreciation be extended to Dr. William E. Dodd, Chairman of the Advisory Council, and his Committee, for the time and effort expended in behalf of the Woman's Auxiliary.

Be it further resolved, that grateful acknowledgment be extended to The Medical Society of New Jersey for the financial assistance given to the Woman's Auxiliary during the fiscal year 1946-1947.

Mrs. Faulkingham moved the adoption of these resolutions. This was seconded by Mrs. Merrill and carried.

CREDENTIALS REPORT

The credentials chairman presented her final report showing a total of 206 members registered.

INSTALLATION OF OFFICERS

The president, Mrs. Frederick G. Wandall, installed the newly elected officers and presented the gavel to Mrs. Lodovico Mancusi-Ungaro.

Mrs. A. Haines Lippincott, president of the Fellowettes, pledged allegiance to the new president and to the incoming officers.

COMMITTEE APPOINTMENTS

Mrs. Mancusi-Ungaro stated that Mrs. Wandall had granted her the privilege of meeting with the old Board and the new Board in order to ratify the committee appointments. Mrs. Mancusi-Ungaro announced these appointments and introduced the chairmen present. The new president indicated that she would like to extend a courtesy membership to Mrs. Royal A. Schaaf, wife of the president of The Medical Society of New Jersey. Mrs. Van Ness moved that Mrs. Schaaf be extended a courtesy membership. This was seconded by Mrs. Dodd and carried.

Mrs. Thomas P. McConaghy and Mrs. R. B. Walker were named to serve on the reading committee.

There being no further business the president declared the 20th Annual Meeting Adjourned.

Approved by Reading Committee
Mrs. Thomas P. McConaghy
Mrs. R. B. Walker

Respectfully submitted,
MRS. BANKS S. BAKER,
Secretary.

III. POST-CONVENTION BOARD MEETING*

The post-convention meeting of the Board of the Woman's Auxiliary was held at Haddon Hall, Atlantic City, on April 24, 1947. The newly elected president, Mrs. Lodovico Mancusi-Ungaro called the meeting to order and led in the citation of the pledge of loyalty to the Auxiliary. Three special guests were then introduced. They were: Mrs. George McIlfatrick, president of the Woman's Auxiliary to the Medical Society of Delaware; Mrs. Robert B. Walker, president-elect of our own state Auxiliary, and Mrs. David B. Allman, first vice-president of the Auxiliary to the American Medical Association.

After roll-call, minutes of the preconvention meeting (see page 37 these TRANSACTIONS) were read and approved. The treasurer's statement (which showed a balance of $697.64) was accepted as read. Mrs. Philip J. Santora, the corresponding secretary, read three communications, as follows:

1. Mrs. Robert Walker's letter of resignation as director.
2. A letter from the editor of the JOURNAL of The Medical Society of New Jersey inviting the newly elected president to a meeting to discuss joint problems for the 1947-1948 season.
3. A letter from Mrs. Jesse D. Hamer, president of the Auxiliary to the American Medical Association, inviting Mrs. Mancusi-Ungaro to serve as chairman of the committee on courtesy resolutions for the 1948 convention.

Mrs. Mancusi-Ungaro thanked the Fellowettes for their pledge of support and called on them for suggestions. She then gave an informal report explaining plans for the coming year, highlighted by the following ten-point program:

1. Promote friendliness among the wives of physicians.
2. Increase membership in our Auxiliary.
3. Organize the presently unorganized counties in New Jersey.
4. Assist The Medical Society of New Jersey at all times when requested.
5. Promote the circulation of *Hygeia.*
6. Support actively all health movements endorsed by The Medical Society of New Jersey.

* Preceding this meeting, members of both Boards were entertained at breakfast by Mrs. Mancusi-Ungaro. Our guests then included Dr. Royal A. Schaaf (president, The Medical Society of New Jersey), Dr. William E. Dodd (chairman of our advisory committee) and Mr. Arthur Conrad (Associate Administrator, National Physicians Committee).

7. Promulgate favorable publicity for the physicians through all media of communications.

8. Coordinate and integrate the functioning of the component auxiliary committees with the corresponding committees of The Medical Society of New Jersey by means of an annual "work-shop".

9. See that our members know the position of all legislators on health questions, and that analysis of pending legislation be distributed effectively.

10. Assume leadership among the women's groups of New Jersey in health education.

The president called on outgoing and incoming officers, committee chairmen, county presidents and presidents-elect for suggestions.

NEW BUSINESS

Mrs. Wandall moved that we accept the resignation of Mrs. Robert B. Walker as a director. This was seconded by Mrs. Mason and carried. Mrs. Baker nominated Mrs. A. J. Casselman as a director to fill the unexpired term of Mrs. Walker. This was seconded by Mrs. McDonnel and carried.

Mrs. McDonnel moved that we authorize the president to proceed with plans for the "work-shop" in connection with The Medical Society of New Jersey. This was seconded by Mrs. Wandall and carried.

Mrs. McConaghy moved that the president and chairman of public relations be authorized by the Executive Board to proceed with the plans for holding a round-table conference at the Executive Office in Trenton, and to proceed with plans for cooperating with the Medical Society in holding their Health Week in October. This was seconded by Mrs. Santora and carried.

Mrs. Ulmer moved that this Board approve the ten-point plan presented by Mrs. Mancusi-Ungaro. This was seconded by Mrs. Jessurun and carried.

The county presidents were urged to check the rosters of officers and members sent to Trenton in order that these lists may be accurate.

Mrs. McDonnel moved that the question of purchasing addressograph plates be referred to the finance committee and that the president be authorizd to proceed if funds are available. This was seconded by Mrs. Dodd and carried.

Mrs. Wandall moved the elimination of the *Program Book* as printed last year. This was seconded by Mrs. Yaguda and carried.

Mrs. McDonald suggested that each officer and chairman send in her proposed budget in order that the finance committee may, in a democratic manner, make up the budget for the coming year.

Mrs. Mancusi-Ungaro read letters from Dr. W. W. Bauer (Bureau of Health Education, American Medical Association), Miss Margaret N. Wolfe, (Executive Secretary of the national Auxiliary) and Dr. William E. Dodd (chairman of our advisory committee) approving her plan for the "work-shop" and Round Table Conference.

Mrs. Wandall moved that the treasurer, Mrs. G. E. McDonnel, be authorized to have a check book printed. This was seconded by Mrs. McDonald and carried.

There being no further business the meeting adjourned.

Respectfully submitted,

MRS. BANKS S. BAKER,
Recording Secretary.

IV. REPORT OF OUTGOING PRESIDENT

MRS. FREDERICK G. WANDALL

My first official duty on taking office in May 1946, was to meet with Dr. William E. Dodd, and go over a planned program for 1946-1947. During June, the state chairmen studied these plans and formulated their programs for the *Year Book*. In July, I attended the convention of the Woman's Auxiliary to the American Medical Association. With the program chairman's untiring efforts, during the same month the *Year Book* was made ready and sent to the printer. In September, I held a conference of county presidents, at which the state chairmen presented their program. The *Hand-Book of the National Auxiliary,* the *Constitution and By-Laws*, the program of the year (embellished with the new seal), pamphlets on the Medical-Surgical Plan, and socialized medicine, and official stationery were given to all members of the executive board.

During 1946-1947, I presided at three executive board meetings. Three special meetings of the Advisory Board were also held, and twenty official visits were made. Ten President's *Messages* appeared in the JOURNAL of The Medical Society of New Jersey. In December 1946, I went to Chicago for the conference of state presidents and presidents-elect.

Letters were sent to county presidents eight times during the year, over my signature. The executive board was notified of all regular meetings. Letters were written to the medical societies of all unorganized counties three times, at proper intervals. Personal contacts were made and personal letters written, in an attempt to organize new county auxiliaries.

I represented the Auxiliary at the forum of the Newark Safety Council, and at the seventeenth Annual Health Institute of the Woman's Auxiliary to the Philadelphia County Medical Society.

All State Medical Society requests were immediately taken care of. Dr. Harrold Murray, chairman of the Child Health Survey, asked our assistance twice; Dr. Henry A. Davidson, editor of the JOURNAL, requested a survey of newspapers in the state for *Health Hints*. This also was done.

Accomplishments during 1946-1947 may be summarized as follows:

1. An official seal was adopted.
2. Revised Constitution and By-Laws were printed.
3. An advisory council to county auxiliaries was appointed in each of six medical societies. Thus, every organized county is finally equipped with an advisory council.
4. Two counties were reactivated.
5. An increase of 40 in *Bulletin* subscriptions, to a new total of 164.
6. Our membership increase was 117. Membership as of April 1st was 1063.

These statistics were the results of the untiring efforts of the whole executive board. Their cooperation and ready willingness to carry out their many duties, helped to lighten the burden of work which is always a part of the duties of the president.

Having gone forward a few more paces, with accomplishments in all fields of endeavor, we look forward not back, and await the beckoning call of our new president, Mrs. Lodovico Mancusi-Ungaro.

V. TREASURER'S REPORT

MRS. THOMAS P. MCCONAGHY, Treasurer

Schedule A. Balance on hand, May 22, 1946.

General Account	$ 356.58
Emergency Account	245.90
Medical Society Account	409.65
Total	$1,012.13

The Medical Society account has since been eliminated, and its assets transferred to the general account. There has also been a transfer of $200 from the emergency account to the general account, by reason of National Convention expenses in July 1946. The readjustment balance therefore reads as follows:

Balance on hand:

Emergency account	$ 45.90
General account	966.23
Total balance	$1,012.13

Schedule B. Receipts

1—From Medical Society	$1,600.00
2—Sale of Hand-Books	4.25
3—Sale of Bill-Heads	3.50
4—Sale of Index-Cards	4.00
5—Dues overpayment (Monmouth Co.)	16.00
6—Dues from county auxiliaries	595.80
7—Dues from members at large	5.00
Total Receipts	$2,228.55

Schedule C. Allocation of Accounts

1—GENERAL ACCOUNT

On hand (May 1946)	$ 966.23
Received	2,168.47
Total	$3,134.70

2.—EMERGENCY ACCOUNT

On hand (May 1946)	$ 45.90
Received	60.08
Total	$ 105.98

3—TOTALS

General account	$3,134.70
Emergency account	105.98
Grand Total	$3,240.68

Schedule D. Disbursements

1—Chairman, organization	$ 3.00
2—Chairman, medical history	3.80
3—Medical Society, postage	1.32
4—Medical Society, mimeographing	4.55
5—Chairman, Historian	4.65
6—Annual Meeting fund	278.42
7—Delegates to San Francisco	1,000.00
8—Year-books and covers	129.53
9—Postage for year-books	24.66
10—Handbooks	6.25
11—Printing	76.30
12—Flowers	11.00

13—Health and Sanitary Ass'n	5.00
14—National dues	239.50
15—Engraving brass plate	3.43
16—President's pin	32.00
17—Return of overpayment	16.00
18—President's expenses	242.21
19—Treasurer's expenses	4.00
20—Treasurer's bond	5.00
21—Committee expenses	23.42
22—State convention account	250.00
23—National convention tea	100.00
Total Disbursements	$2,464.04

Schedule E. Recapitulation

Assets total, from Schedule C	$3,240.68
Disbursements, Schedule D	2,464.04
Balance on hand, April 23, 1947	$ 776.64

Schedule F. Allocation of Balance

General Account	$ 670.66
Emergency Account	105.98
Balance on hand	$ 776.64

Schedule G. Investments

U. S. Bond, Series F, No. 4C742366	$ 100.00
U. S. Bond, Series F, No. C1065402F	100.00

AUDIT

We, the auditing committee, having checked the treasurer's books, find that they are accurate.

MRS. CHESTER I. ULMER,
MRS. BANKS S. BAKER,
MRS. G. E. McDONNEL, Chairman.

THE N.Y. ACADEMY OF MEDICINE
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CLINICAL CONFERENCE, OCTOBER 29—See Page 376

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

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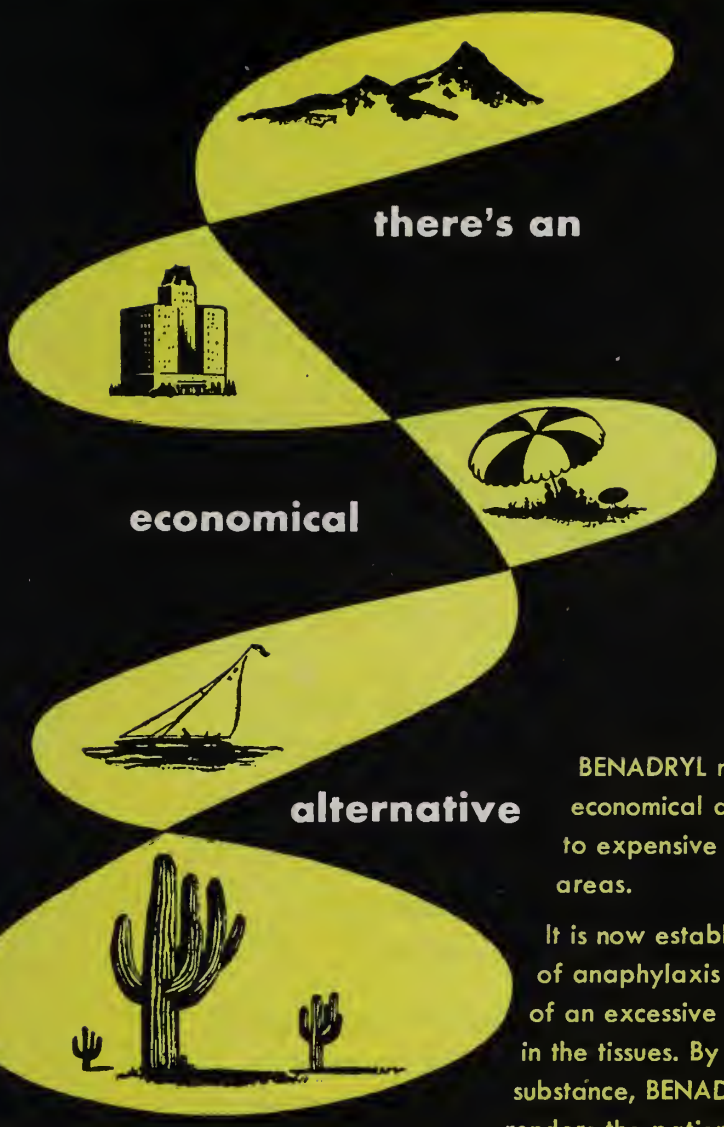


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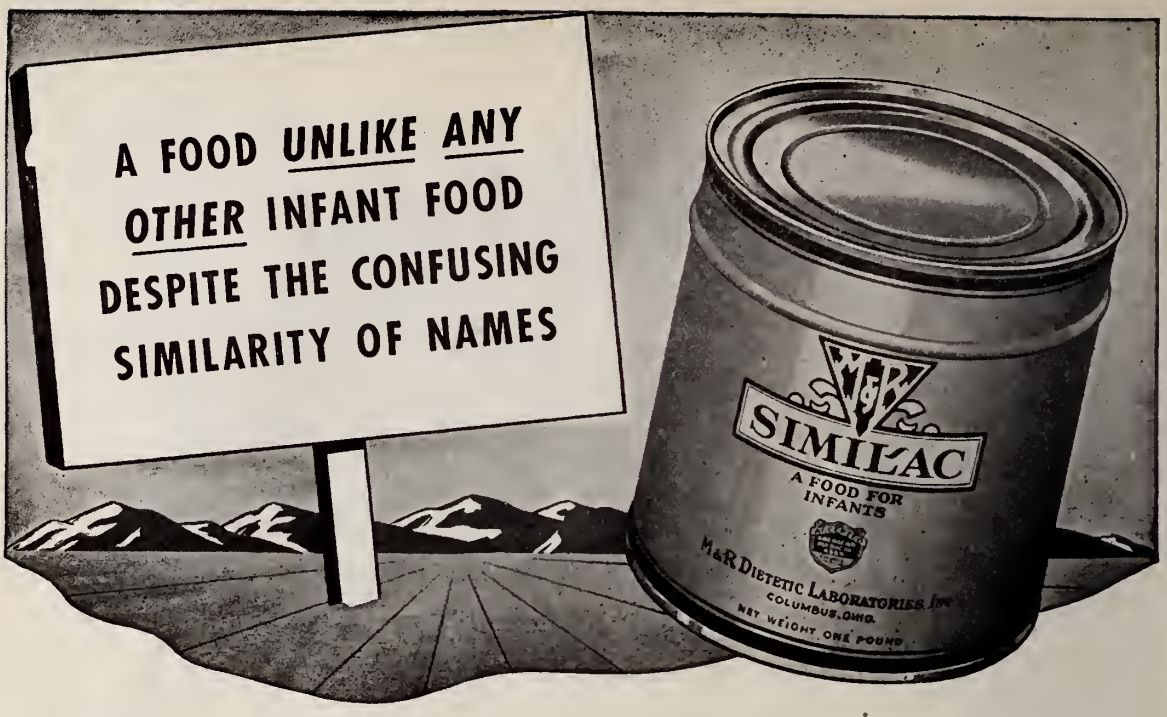


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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154.*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.

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1. Anderson, N. A.: Penn. Med. J., *48*:566-8 (Mar.) 1945

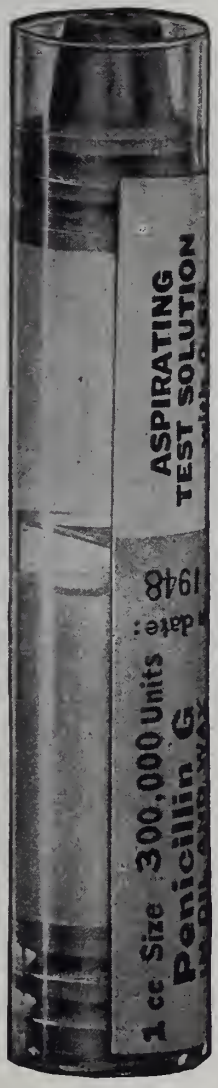
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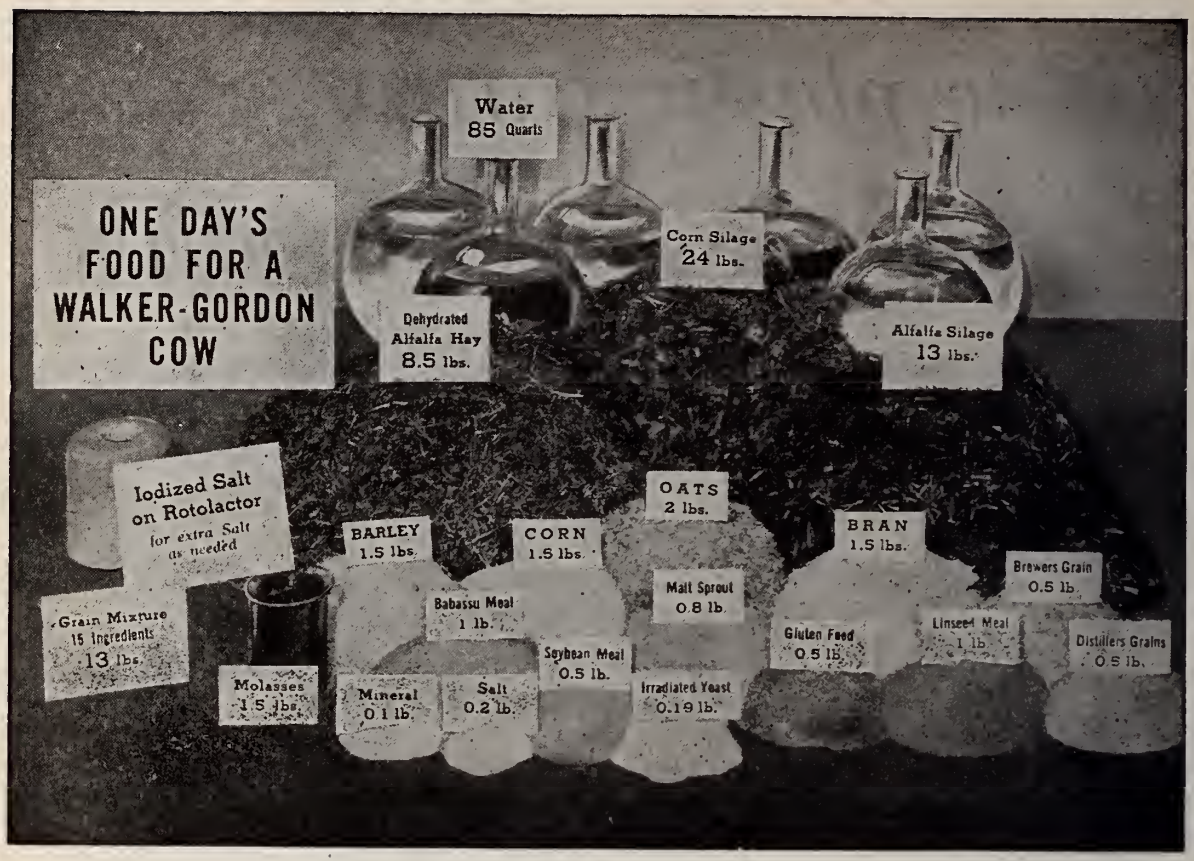
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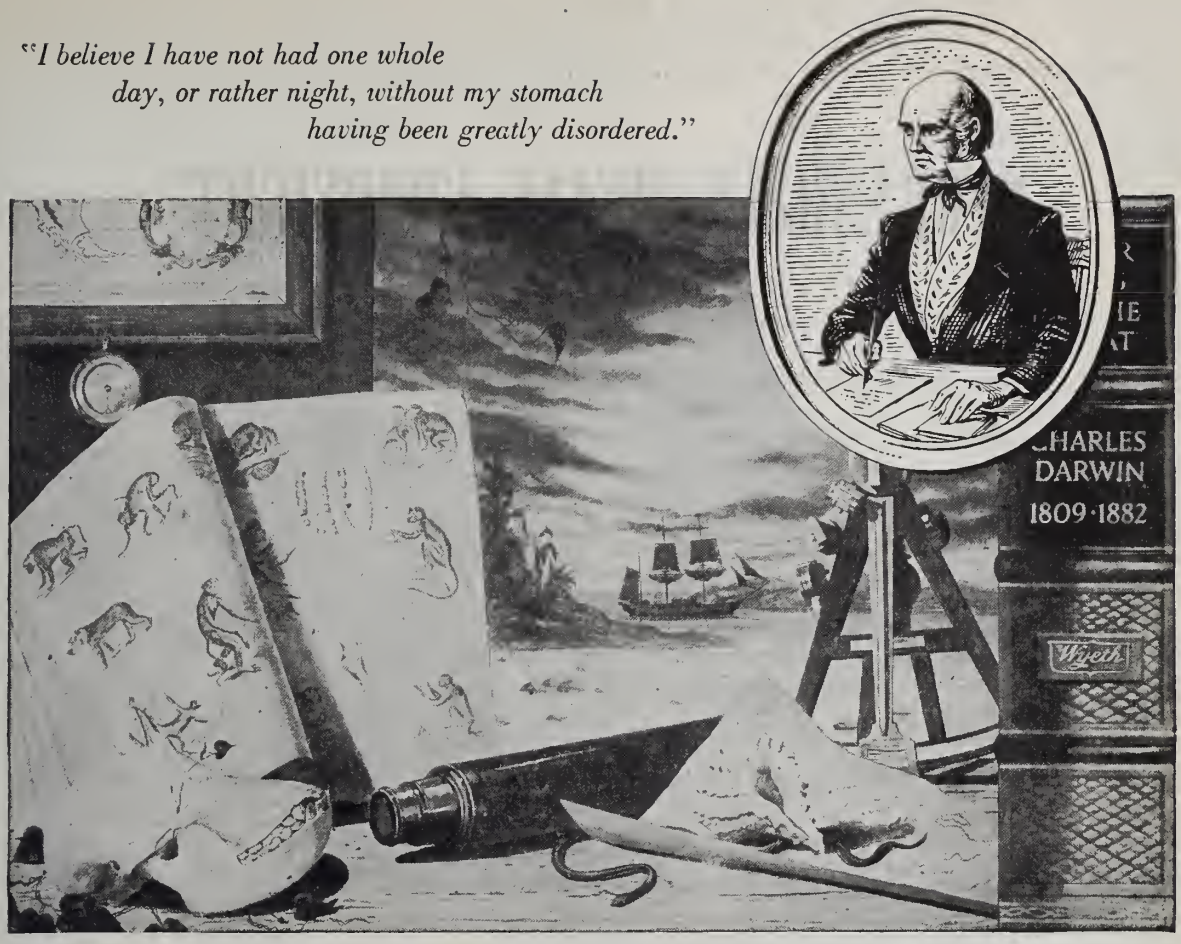
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[1]*Rehfuss, M. E., The Ulcer Life, Clinics 3:480-493 (Oct.) 1944*

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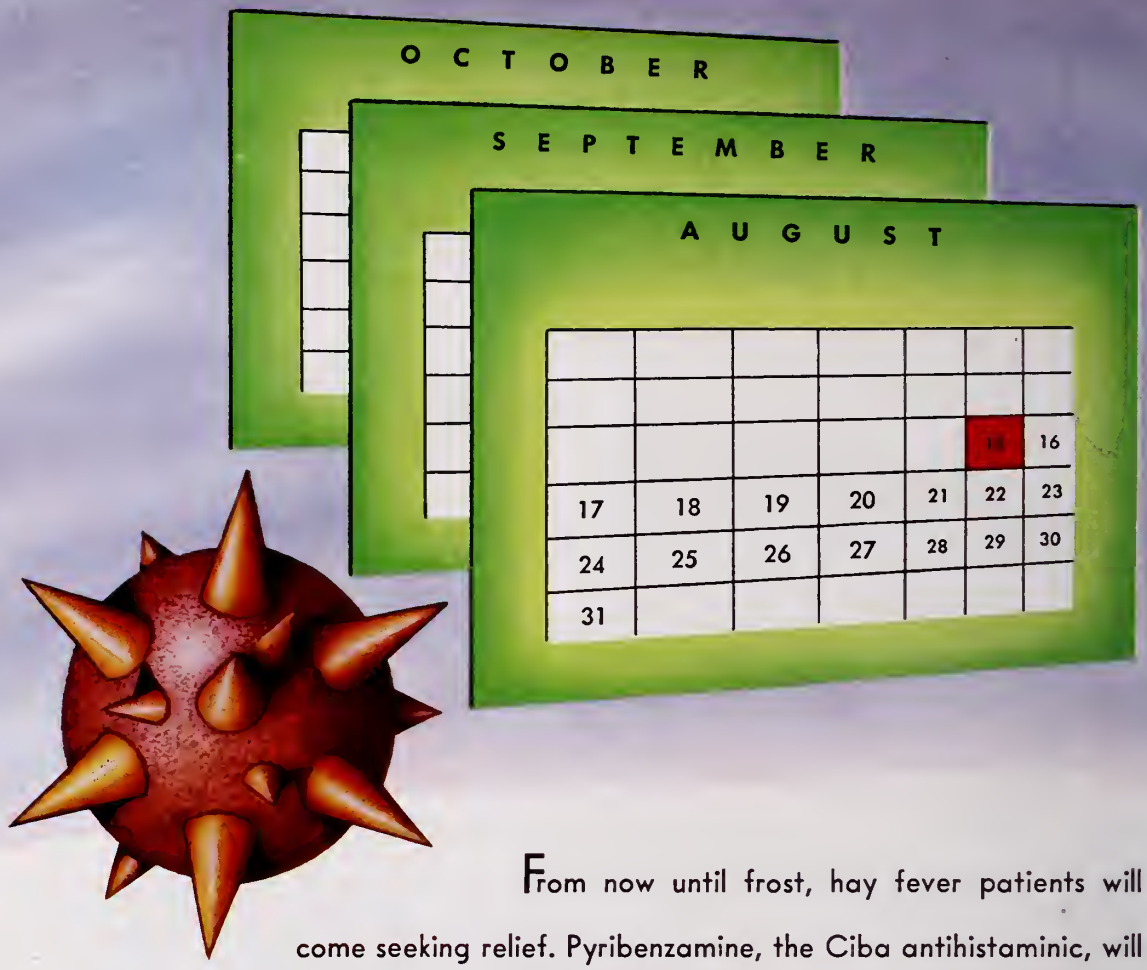
PYRIBENZAMINE

PYRIBENZAMINE ® (brand of tripelennamine)

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

CIBA PHARMACEUTICAL PRODUCTS, INC.

SUMMIT, NEW JERSEY



From now until frost, hay fever patients will come seeking relief. Pyribenzamine, the Ciba antihistaminic, will give benefit to a large percentage of them. In various series, from 62 to 85 per cent have been symptomatically relieved. For practical purposes, Pyribenzamine can be regarded as giving a comparatively low frequency and intensity of side reactions.

PYRIBENZAMINE HYDROCHLORIDE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Production and nation-wide distribution of Pyribenzamine have now been increased so that you can prescribe this drug for your hay fever and other allergic patients with assurance that your local pharmacist can supply it promptly.



SUPPLIED: Scored tablets of Pyribenzamine hydrochloride, 50 mg. Bottles of 50 and 500.

CIBA PHARMACEUTICAL PRODUCTS, INC.

SUMMIT, NEW JERSEY

2/1219

With this in hand



The Cardiologist is assured of

Dependability in Digitalis Administration

Being the powdered leaves made into
physiologically tested pills,
all that Digitalis can do, these pills will do.

Trial package and literature sent to physicians on request.

DAVIES, ROSE & COMPANY, Limited
Manufacturing Chemists, Boston 18, Massachusetts

D14

Designed to Assist the Patient



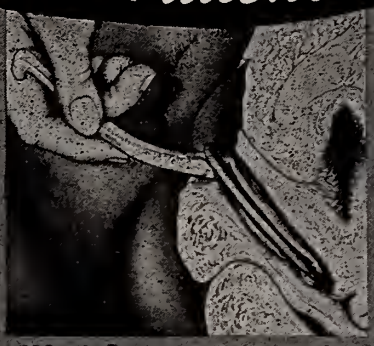
NO. 1 Beginning placement of diaphragm on introducer.



NO. 2 Diaphragm placed on introducer.



NO. 3 Application of jelly to diaphragm.



NO. 4 Beginning insertion of diaphragm.



NO. 5 Placement of diaphragm.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMA

The insertion and correct placement of the "RAMSES"* Flexible Cushioned Diaphragm are simplified by the use of the "RAMSES" Diaphragm Introducer as illustrated.

Our booklet, "Instructions For Patients", will be found helpful in guiding patients in the proper use of the "diaphragm-jelly technique". A supply will be sent to physicians on request.

A MARK OF Ramses DEPENDABILITY

gynecological division

JULIUS SCHMID, INC. 423 WEST 55th ST., NEW YORK 19, N. Y.

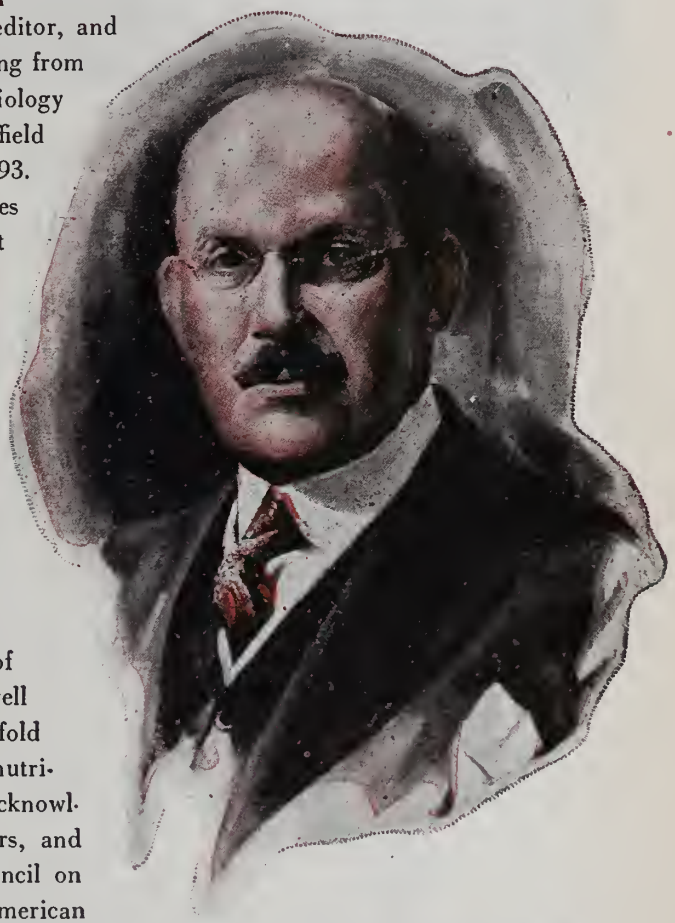
quality first since 1883

*The word "RAMSES" is a registered trademark of Julius Schmid, Inc.

Men and Amino Acids

Lafayette B. Mendel is recognized as a pioneer in the science of nutrition, and as a writer, editor, and educator of wide influence. On graduating from Yale University in 1891, he studied physiology and physiological chemistry in the Sheffield Scientific School, receiving his Ph.D. in 1893. In 1895 and 1896, he continued his studies abroad under Professor Heidenhain at Breslau, and Professor Baumann at Freiburg. Beginning as an assistant in physiological chemistry at Sheffield, Mendel became a full professor in 1903, and a member of the Governing Board. In 1921 he was named Sterling professor.

For many years, Mendel collaborated with the distinguished investigator of vegetable proteins, Thomas B. Osborne, conducting valuable researches on the comparative biologic value of proteins of differing amino acid composition, as well as in other fields of nutrition. His manifold contributions to our understanding of nutrition in the chemistry of life were acknowledged in numerous lectureships, honors, and awards. He was a member of the Council on Pharmacy and Chemistry of the American Medical Association from 1917 until the time of his death, and of the Committee on Foods from its inception.



LAFAYETTE BENEDICT MENDEL—1872-1935

The Arlington Chemical Company

Yonkers 1, Arlington *New York*

Seventh in a series



The Established Regimen of Spa Treatment Fits Your Program



Here at the Spa your patient has the benefit of a regimen which fits into your program for his treatment.

The full therapeutic benefits of the Spa's naturally carbonated mineral waters are enlisted in this regimen. The program supplements your own medical guidance in the treatment of your patients who are suffering from cardiac, vascular or rheumatic disorders of a chronic nature.

Surrounded by superb man-made facilities, in a setting of great natural beauty, your patient is ideally prepared for the full benefit of your continuing care.

Capable physicians are available in Saratoga Springs for consultation with your patient on the details of your program.

"PHYSICIAN, GIVE HEED TO THINE OWN HEALTH"

Many physicians have come to the Spa for the same kind of treatments that have helped their patients here. After a restorative "cure" at the Spa, you, too, will return to your practice refreshed—revitalized—ready for the busy days that lie ahead.

For professional publications of the Spa, and physician's sample carton of bottled waters, with their analyses, write W. S. McClellan, M. D., Medical Director, Saratoga Spa, 159 Saratoga Springs, New York.

Listed by the Committee on American Health Resorts of the American Medical Association

THE EMPIRE STATE'S CONTRIBUTION TO THE MEDICAL PROFESSION

ACCEPTED
COUNCIL ON PHARMACY AND CHEMISTRY
AMERICAN MEDICAL ASSOCIATION

for use in control of overweight—

Benzedrine Sulfate has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association

According to Freed (J. A. M. A., Feb. 8, 1947), "Benzedrine Sulfate . . . is of inestimable value in controlling the desire for food and in reducing the level of satiability to a more normal one. This drug is commonly administered in dosages of 5 mg. three times a day, thirty to sixty minutes before each meal. Occasionally patients will require 10 mg. at one or more times during the day, depending on their response to the drug."

The use of Benzedrine Sulfate alone ordinarily should achieve the desired appetite reduction. Combinations of amphetamine and thyroid serve no useful purpose and may even be dangerous. In this connection, a recent report of the Council (*Drugs for Obesity*, J. A. M. A., June 7, 1947) says: "The fallacy and dangers of overstimulating the body with thyroid and of using laxatives to aid in reduction are well known to the medical profession."

b

benzedrine sulfate

Smith, Kline & French Laboratories, Philadelphia

(*racemic amphetamine sulfate, S.K.F.*)

One of the fundamental drugs in medicine



Eminent critic . . . . . dietary dub!

At meal time his renowned judgment deserts him. Eating only the food he likes, a choice of notably limited range, he thrice daily produces a burlesque on proper nutrition. Inevitably, this perennial first-nighter makes his entrance into some physician's reception room—the victim of a self-made, borderline vitamin deficiency. In the same cast, you will find other familiar types. Included in it are the ignorant and indifferent, people "too busy" to eat properly, those on self-imposed and badly balanced reducing diets, excessive smokers, food faddists and alcoholics, to name a few. First thought in such cases is dietary reform, of course. Along with that, a dependable vitamin supplement may well be in order. When you prescribe an *Abbott* vitamin product, you are assured that the patient will receive the full vitamin potencies intended. Your pharmacy carries a complete line of Abbott vitamin products in a variety of dosage forms and package sizes, and will be pleased to fill your prescriptions. ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS.

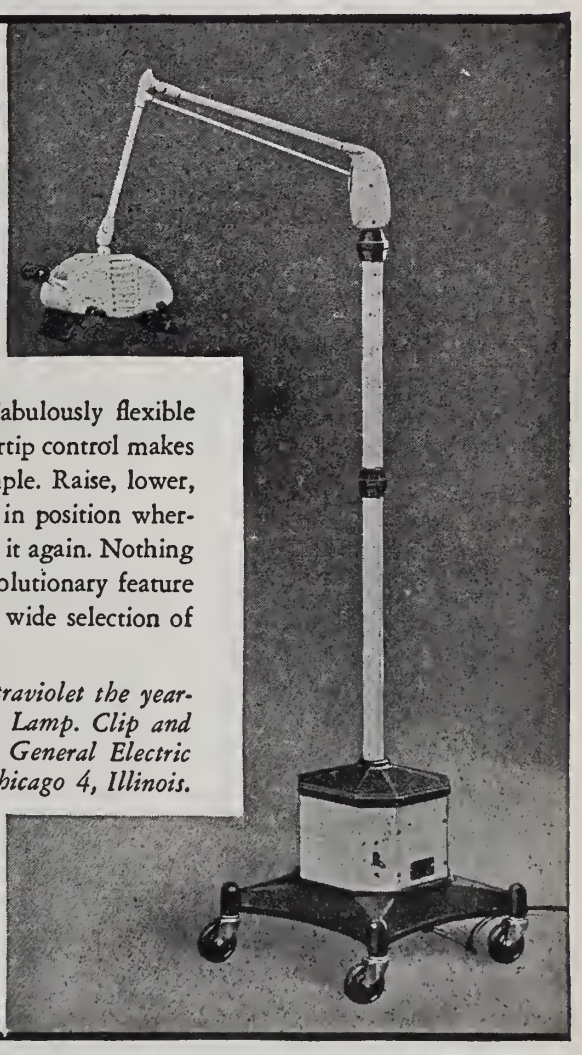
SPECIFY

Abbott Vitamin Products

G-E X-RAY PROUDLY ANNOUNCES

THE NEWEST ADDITION TO THE FAMILY

The G-E Prescription Model Ultraviolet Lamp offering you all the famous G-E X-Ray quality and service in a new low cost ultraviolet lamp.

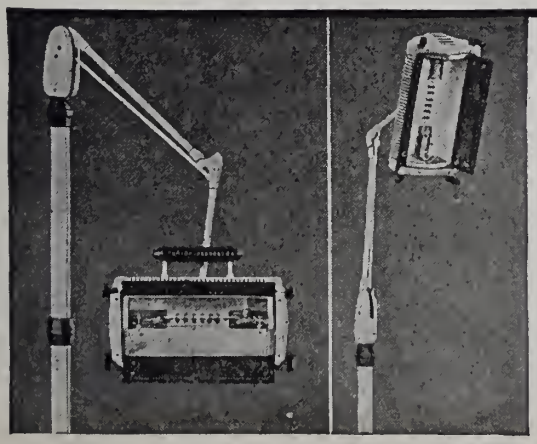


This new, economically priced lamp features the famous G-E Uviarc high pressure mercury quartz burner—economical to operate and with emission characteristics covering the full range of therapeutic ultraviolet. Long familiar to users of G-E professional type lamps, the Uviarc burner emits intense, uniform radiation throughout the spectral bands of proven clinical value.

The compact, sturdily constructed burner housing is mounted on the Dazor Floating Arm. Fabulously flexible and almost human, this remarkable arm with its fingertip control makes the positioning of the lamp amazingly swift and simple. Raise, lower, swing the burner housing through an arc; it freezes in position wherever you stop it—and it stays there too until you move it again. Nothing to tighten, no time consuming adjustments. This revolutionary feature facilitates rapid positioning of the lamp and offers a wide selection of treatment distances.

Plan now to offer your patients the benefits of ultraviolet the year-round with the G-E Prescription Model Ultraviolet Lamp. Clip and mail the convenient coupon today to: Dept. 2667, General Electric X-Ray Corporation, 175 West Jackson Boulevard, Chicago 4, Illinois.

GENERAL ELECTRIC X-RAY CORPORATION



℞ Please send me detailed information on your new Prescription Ultraviolet Lamp.

Name_____

Address_____

City_____

State or Province_____

2667

When patients on soft, smooth diets require high protein intake



Swift's Strained Meats



specially prepared—offer an appetizing, natural source of complete, high-quality proteins

Many doctors now recommend Swift's Strained Meats for patients on soft, smooth diets where a high-protein intake is required. These specially prepared meats provide a highly palatable source of biologically complete proteins, B vitamins and minerals in a form desirable for a soft oral diet. Swift's Strained Meats may easily be used in tube-feeding, too—the minute particles of meat are so fine.

Tempting variety of 6 different kinds

The wholesome meat flavors in Swift's Strained Meats are readily accepted by most patients—even when appetite is impaired. The variety includes: beef, lamb, pork, veal, liver and heart. Prepared with expert care from selected, lean U. S. Government Inspected Meats, Swift's Strained Meats are carefully trimmed to reduce fat content to a minimum. Each tin of Swift's Strained Meats contains three and one-half ounces.

All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Also . . . Swift's Diced Meats

Those tender cubes of juicy, lean meat are highly desirable for patients who can eat meat in a form more nearly like that of ordinarily prepared meats. Swift's Diced Meats are soft and may easily be mashed to the desired consistency. Six kinds: beef, lamb, pork, veal, liver and heart. Five ounces per tin.

We will be happy to send you complete information and complimentary samples of Swift's Strained and Swift's Diced Meats. Please write Swift & Company, Dept. B. F., Chicago 9, Illinois.

SWIFT QUALITY FOODS

SWIFT & COMPANY • CHICAGO 9, ILLINOIS



FOR AN ACTIVE MIDDLE AGE

A "PLUS"

The "plus" is the gratifying "sense of well-being" so many menopausal patients experience following "Premarin" therapy. It is the intangible factor which, added to relief of distressing symptoms, enables the middle-aged woman to resume her normal routine of useful and enjoyable activities.

"Premarin" provides naturally occurring, conjugated estrogens for effective therapy by the oral route. Untoward side effects are rarely noted with "Premarin."

"Premarin" is now available as follows:

Tablets of 2.5 mg. . . . . in bottles of 20 and 100
Tablets of 1.25 mg. . . . . in bottles of 20, 100 and 1000
Tablets of 0.625 mg. . . . . in bottles of 100 and 1000
Liquid containing 0.625 mg. per 4 cc. (one teaspoonful) . . . in bottles of 120 cc.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are also present as water-soluble sulfates. The water solubility of conjugated estrogens (equine) permits rapid absorption from the gastrointestinal tract.

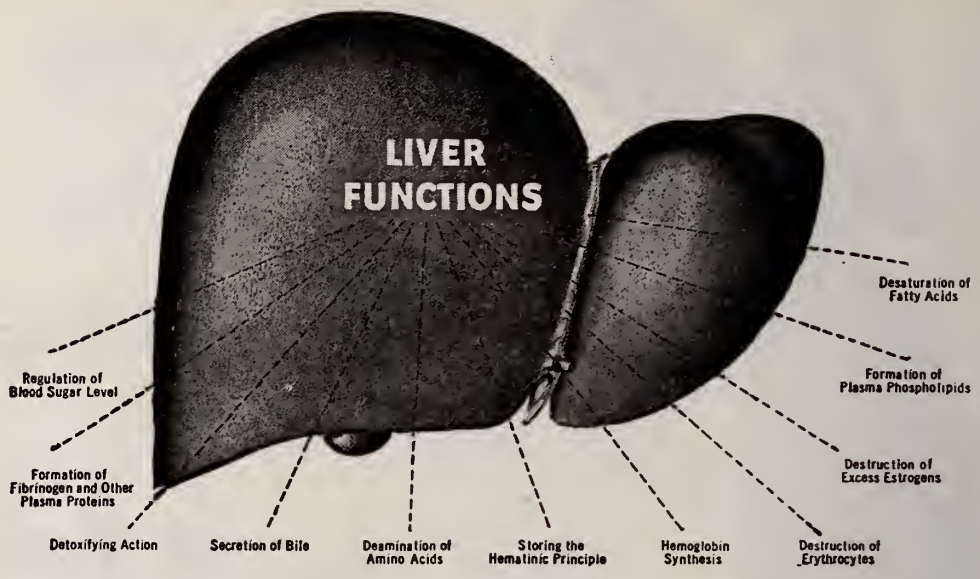
ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

CONJUGATED ESTROGENS
(equine)

"Premarin"®

AYERST, McKENNA & HARRISON Limited

22 EAST 40th STREET, NEW YORK 16, N. Y.



To Guard the Functional Integrity of the LIVER

The complex nature of the manifold functions of the liver is reflected in the diagram shown above. To maintain its functions in an efficient manner, the liver must be adequately protected against toxic influences. Parenchymatous damage with ensuing decreased functional capacity can lead to severe metabolic derangements.

Protein deficiency is an important factor in precipitating impaired liver function. Hence an adequate intake of biologically complete protein, ordinarily in the form of protein foods, is indispensable as a safeguard of liver competency.

Among man's protein foods, meat ranks high not only because of its generous content of protein, but also because its protein is complete, capable of satisfying all protein requirements. Furthermore, all meat is 96 to 98 per cent digestible.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

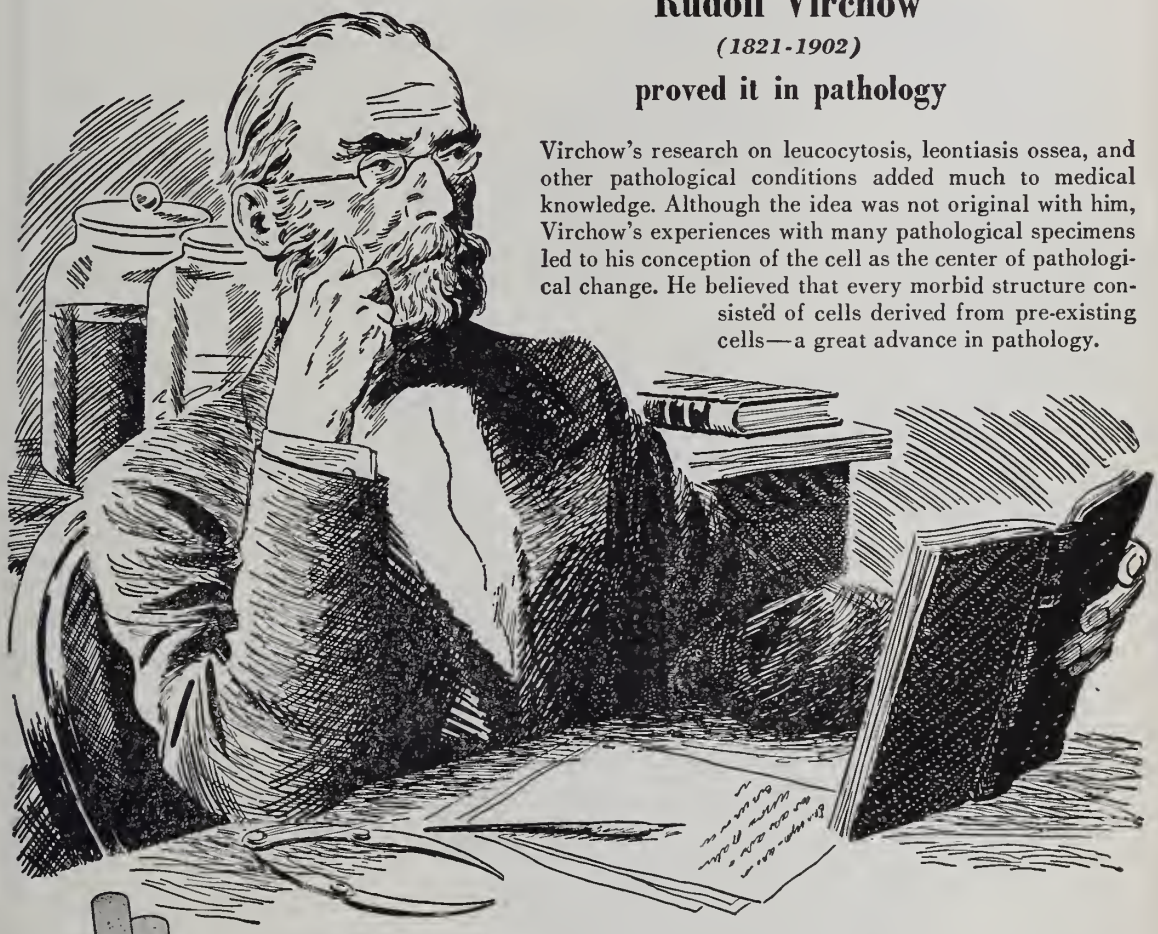
Experience is the Best Teacher

Rudolf Virchow

(1821-1902)

proved it in pathology

Virchow's research on leucocytosis, leontiasis ossea, and other pathological conditions added much to medical knowledge. Although the idea was not original with him, Virchow's experiences with many pathological specimens led to his conception of the cell as the center of pathological change. He believed that every morbid structure consisted of cells derived from pre-existing cells—a great advance in pathology.

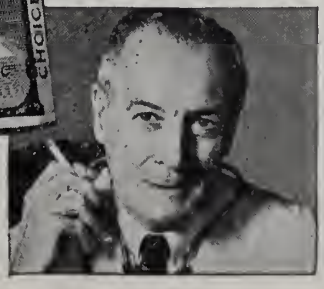


Yes, and experience is the best teacher in smoking too!

EXPERIENCE during the wartime shortage taught smokers the differences in cigarette quality. Millions of people smoked more different brands then than they would normally have tried in years. More smokers came to prefer Camels as a result of that experience, so that today more people are smoking Camels than ever before.

But, no matter how great the demand, we don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.





According to a recent Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

R. J. Reynolds Tobacco Co.
Winston-Salem, N. C.

PROFESSIONAL LIABILITY PROTECTION

Afforded Members of

THE MEDICAL SOCIETY OF NEW JERSEY

Since 1921

FAULHABER & HEARD, Inc.

Authorized b r o k e r to negotiate professional liability contracts for The Medical Society of New Jersey

CONSULT US

For Protection and Specialized Service

31 Clinton Street Newark, N. J.

Telephone MItchell 2-1294

FAULHABER & HEARD, Inc.

31 CLINTON STREET **NEWARK, N. J.**

Kindly send information on limits and costs of Society Professional Policy.

Name.....

Address.....

.....

For better skin care

Even the mildest soaps contain fatty acids and alkali which, on continued use, may become a source of irritation that produces or aggravates eczematous lesions.

pHisoderm the modern soapless detergent, has the same *pH* as the normal skin and is hypoallergenic, containing no fatty acids, alkali, color or perfume. *pHisoderm* effectively cleans without irritation. It makes an abundant lather in hard and cold water, and is approximately 40 per cent more surface active than soap.



Write for detailed literature and samples.

pHisoderm

Trademark reg. U. S. Pat. Off. & Canada

sudsing detergent cream

Regular, Oily and Dry Types in bottles of 2 oz., 7 oz., 12 oz. and 1 gallon. Also in 3 oz. refillable hand dispensers.

WINTHROP

Winthrop

CHEMICAL COMPANY, INC.

NEW YORK 13, N. Y. • WINDSOR, ONT.



WELL TOLERATED by the NEWBORN

Clinical experience establishes that CARTOSE* is especially well tolerated by newborn infants.

CARTOSE supplies carefully balanced amounts of non-fermentable dextrins, with maltose and dextrose. These offer the advantages of: spaced absorption because of the time required for hydrolysis of the higher sugars; less likelihood of distress due to the presence of excessive amounts of fermentable sugars in the intestinal tract at one time.

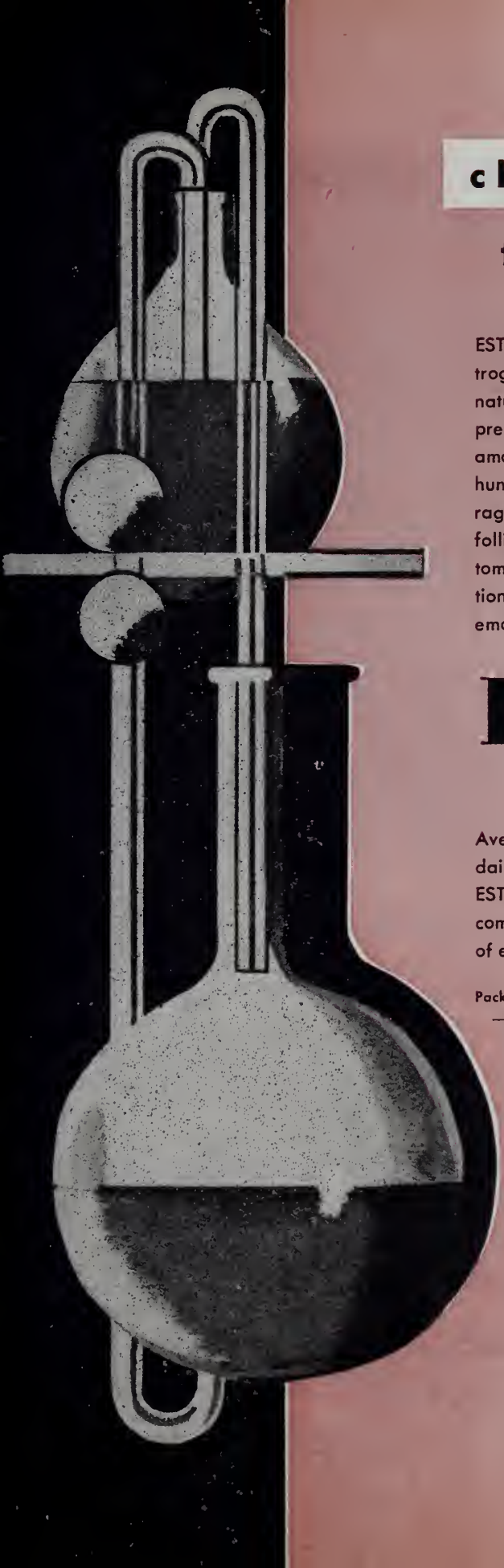
CARTOSE is liquid; formula preparation is simple, rapid, and accurate. It is compatible with any formula base: fluid, evaporated, or dried milk.

*The word CARTOSE is a registered trademark of H. W. Kinney and Sons, Inc.

ACCEPTED AMERICAN MEDICAL ASSN.

CARTOSE
REG. U. S. PAT. OFF.
Mixed Carbohydrates

H. W. KINNEY & SONS, INC. (Kinney trademark) **COLUMBUS, INDIANA**



chemically similar to natural estrogens

ESTINYL (ethinyl estradiol) is "chemically similar to natural estrogen."[1] It is more active *orally* than any other synthetic or natural estrogen known today. ESTINYL is the first estradiol preparation that is efficacious by mouth in really minute amounts. It provides the economy inherent in low dosage. Five-hundredths of a milligram daily is sufficient to relieve the average menopausal patient. ESTINYL, closely allied to the primary follicular hormone, does more than mitigate vasomotor symptoms. ESTINYL quickly relieves the common nervous manifestations and bodily fatigue, and replaces them with a sense of emotional and physical fitness.

ESTINYL

tablets

ACCEPTED Council on Pharmacy and Chemistry American Medical Association

Average menopausal symptoms: One 0.05 mg. ESTINYL Tablet daily. Severe menopausal symptoms: Two or three 0.05 mg. ESTINYL Tablets daily. Many patients may be maintained in comfort with 0.02 mg. ESTINYL Tablet daily after initial control of estrogen deficiency.

Packaging: ESTINYL TABLETS of 0.05 mg.—pink, coated tablets and 0.02 mg.—buff, coated tablets, bottles of 100, 250 and 1,000.

1. Bickers, W.: Am. J. Obst. & Gynec. 51:100, 1946.

Trade-Mark ESTINYL—Reg. U.S. Pat. Off.

Schering CORPORATION
BLOOMFIELD, N. J.

SCHERING



30 day crisis

The first 30 days of life might be called a truly critical period since the greatest number of infant deaths—62.1%—occur during this time. The proportion of infants who die within the first month has, in fact, increased nearly 10% in the past 20 years, while infant mortality on the whole was substantially reduced.*

So much the greater, then, is the importance of providing the most favorable conditions for maximum health during this fatal first month. Considering the role nutrition plays in infant health, a good start on the right feeding warrants special attention.

'Dexin' has proved an excellent "first carbohydrate" because of its high dextrin content. It (1) resists fermentation by the usual intestinal organisms; (2) tends to hold gas formation, distention and diarrhea to a minimum, and (3) promotes the formation of soft, flocculent, easily digested curds. 'Dexin' *does* make a difference.

* Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

'Dexin' Reg. Trademark

HIGH DEXTRIN CARBOHYDRATE **'Dexin'** BRAND

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available Carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.

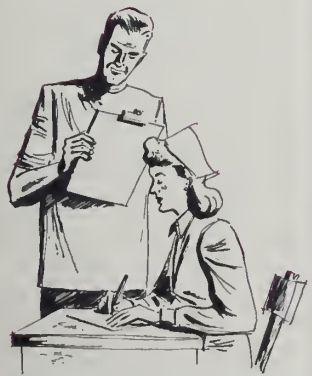
Literature on request

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 East 41st St., New York 17, N. Y.



UNIFORM, ACCURATE,

CAREFULLY STANDARDIZED



SULFA DRUGS bearing the Lilly Label are prominent among the more recent medicinal agents of proved therapeutic value. They are noted for their uniformity in appearance, accuracy of dosage, and careful standardization. Available in logical dosage forms and sizes.

ELI LILLY AND COMPANY

INDIANAPOLIS 6, INDIANA, U. S. A.



A 12x15 reproduction of this Arthur Sarnoff color illustration, suitable for framing, is available upon request.

Doctors and Detectives

THE PHYSICIAN is usually among the first to visit the scene of a tragedy. In solving crime, the type and location of wounds, abrasions, or bruises may have distinct significance. Bloodstains, scientifically examined, may provide the convicting evidence. Skeletal remains often reveal important facts concerning sex and age. Police records emphasize the importance of medical aid in the solution of crime.

Broad knowledge, keen observation, and the ability to piece facts together into a coherent whole are characteristic attributes of the physician. These same accomplishments are equally important in the field of medical research. In the Lilly Research Laboratories, physicians team with specialists in many related fields of science to attack problems which confront the clinician.

Volume 44
Number 9

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904
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Henry A. Davidson, M.D., Editor

Miriam N. Armstrong,
Assistant Editor

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THE PRESIDENT'S PAGE

WHAT PRICE MEMBERSHIP?

"Why are State Society dues so high?" is a question often directed to officers and trustees of the Society. To many of our members an assessment of $25 a year seems excessive but a brief review of our budget for the ensuing year will, I think, leave the impression that our members are getting full value in return for their contributions to the society treasury. Our activities are many and varied. All of them are essential for the proper conduct of our internal affairs, for the protection of our legitimate professional interests or for the proper discharge of our obligations to the people of our state. Only three of these activities are self sustaining requiring no budgetary expense:—the Journal defrays its own cost of publication, the Annual Meeting operates on the income from the exhibits, and the Medical-Surgical Plan is wholly self supporting.

In our new permanent home we enjoy a central office organization of which we can all be justly proud. In beauty and utility it compares favorably with other state society homes. At $6,500 a year, the operating expenses are not much more than the rental of inferior quarters would be. Our largest single budgetary item is for salaries and wages of the executive staff, a total of $27,000. At first glance, this amount seems large, but, on further study it will seem reasonable in consideration of the number of people we employ and the high quality of training and experience which is required of them.

The next largest item is the appropriation for the legislative committee, $7,000. This includes the salary of the Executive Secretary of the committee as well as incidental expenses. In view of the brilliant success of the committee in

combating undesirable legislation in this state, this expenditure seems almost trivial.

An appropriation of $6,000 for public relations is meager by comparison with the amounts expended by many other state societies, notably California, for this item alone. The activities of the Woman's Auxiliary in the public relations field have enabled us to carry on a fairly effective public relations program at very little cost; but a much larger sum than $6,000 could be expended profitably in this work.

The Veterans Liaison Committee will require $3,000; but, through the efforts of this committee, a very satisfactory program for medical care of veterans with service-connected disabilities has been developed, yielding a large income to individual physicians in the state. The society has already expended over $15,000 in the veterans medical care program but this investment has returned enormous dividends not only in professional fees but through the excellent public relations results which have ensued.

A contribution of $4,160 will be made to the Medical Service Administration and this also has brought us tangible benefits. Through this organization, The Medical Society of New Jersey has evolved its philosophy for the medical care of the sick poor; and through its Newark plan, has brought definite financial returns to our members in the Newark area.

One could continue a critical analysis of the budget item by item, but each one can be justified on the ground that it is the minimum amount consistent with the proper conduct of the particular activity for which the appropriation has been made.

It is my considered opinion that a careful study of our budget will show our members that they are not contributing too much, and will make them wonder how we do so much with so little.

Royal A. Schaaf, M.D.
President.

WILLIAM J. CARRINGTON, M.D. 1884-1947

William J. Carrington was one of the few really effective examples of a "well-rounded man." Our Society abounds in members who are good surgeons, and enjoys its share of serious medical scholars. We also have some (but not enough) doctors who take active roles in civic affairs. All this, Dr. Carrington was and did. But who else have we who could win cups at squash tennis, function as president of the Boy Scouts, write a well-selling popular book, serve as vice-president of the A.M.A., play golf in the eighties, set up a new obstetrical department in a large hospital, win an award as the citizen who had done most to spread the fame of his city, wear the eagles of a full army colonel, and win top honors in two or three branches of medicine and surgery?

The biographic facts are simply told. Dr. Carrington was born in Missouri's capital city on February 4, 1884. He received his B.A. degree at the University of Missouri and then came east to study at the Jefferson Medical College. His leadership manifested itself here, for by the time he was graduated, in 1908, he had become president of his class, and had picked up two prizes for excellence in scholarship. He was one of the few (and the number is really small) chosen by the faculty to serve an internship at the Jefferson Hospital, and then took a year of residency. The following year he moved to Atlantic City and opened an office.

It was in New Jersey that the promise of leadership, first noticed in Missouri and in Pennsylvania, really fulfilled itself. He established the obstetrical department of the Atlantic City Hospital. He became attending gynecologist to the Municipal Hospital in that city. He was elected national president of the Jefferson Alumni Association, and then in rapid order accumulated such honors as presidency of the Atlantic County Medical Society, directorship of the medical staff of the Atlantic City Hospital, fellowship in both the American and International College of Surgeons and, in 1938, the presidency of The Medical Society of New Jersey. He was, of course, a diplomate of the Board of Obstetrics and Gynecology.

During his year as president of The Medical Society of New Jersey, he initiated leadership training for county society officers, thought of and organized the first fall clinical conference of the Society, revitalized the state society's public relations program, and laid the plans for the Medical Service Administration and Medical-Surgical Plan.

He apparently believed in the 40-hour day for himself, since somehow he managed to travel extensively, write articles for the medical journals, keep so active in the Kiwanis that in 1934 he was elected International President of that distinguished organization, become interested in the Boy Scouts and also in banking (he was president of the Scouts, and director of a local bank), write the book *Safe Convoy* (a manual for expectant mothers), serve as vice-president of the A.M.A., head up the county division of the Salvation Army, and through it all, to maintain a busy surgical practice. In 1938, it was no surprise to learn that the Press Club presented him with the award for "doing most to spread the fame of Atlantic City."

In 1942, with the war underway, he decided that he ought to enter the Army. He was 58 years old at the time and had certainly earned the right to stay home with his friends and family and sit the war out on the sidelines. But that wasn't his way. He entered the Army became chief of the Surgical Service at the Shick General Hospital in Clinton, Iowa, and, in spite of his age, kept demanding foreign service. He was soon promoted to full colonel, and remained on active duty until the middle of 1946.

One of his Atlantic County colleagues, a man who had often been listed as his political opponent in some of the Society's debates, was once asked to summarize his impressions of Bill Carrington. "He did more things well than any any man I know of" he said. "He could take out tonsils or a gall bladder or a uterus and have it look like a text-book demonstration. He was near the top of the list at the Racquet Club and survived several rounds of important squash tournaments even after he passed the half-century mark. He was a second baseman of no mean talent even at the age of 55. He took up golf at 45 and within one year was playing in the eighties."

In addition to this amazing round of surgical, civic, athletic, literary and organizational activities, Bill Carrington proved himself a top-notch administrator. In the Army, in the administration of the hospital staff, in his services as president of county and state societies, in his work with the Kiwanis, he demonstrated that true executive skills did not depend on being pompous or rigid, but that all leadership was more effective for the breath of laughter, the sense of proportion, and the radiation of personal warmth which, more than his countless honors, will always be associated with the name of William J. Carrington.

ORIGINAL ARTICLES

THE CONTROL OF WHOOPING COUGH

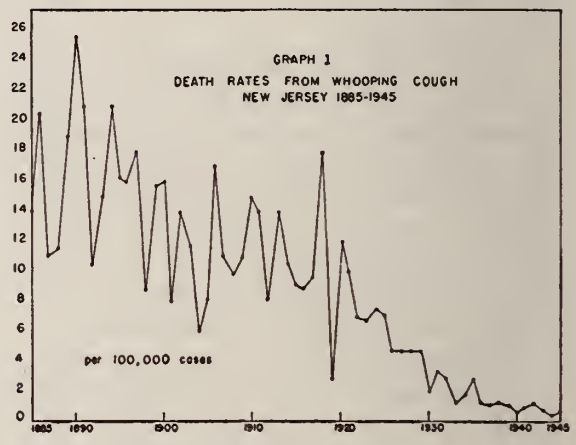
ROSCOE P. KANDLE, M.D.,* Trenton, N. J.

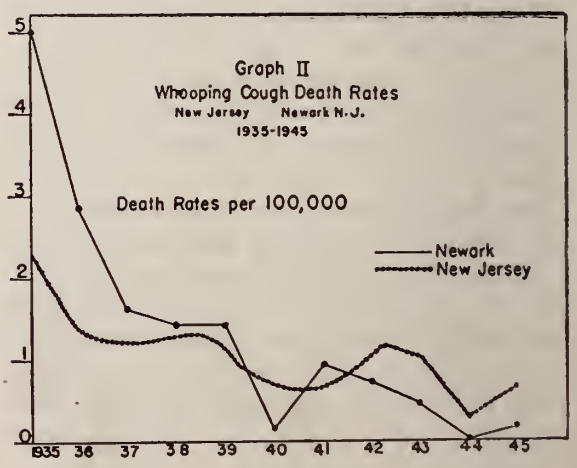
Whooping cough can be the next disease to come under significant control. The tools are at hand: namely, effective vaccines,[1] vaccine control by the mouse protection tests,[2] an understanding of the value and use of booster doses,[3] multiple antigen preparations,[4] a skin susceptibility test,[5] the public health machinery and public acceptance of the basic methods. A most important step in achieving control is a change in the point of view of public health officials, the medical profession, school authorities, and the people from that of a mortality control program to that of morbidity control program.

Mortality control has progressed rapidly, as is well illustrated by the experience in New Jersey. Yet the job is not finished. In Graph I, it will be noticed that there was a slow trend of the death rate downward until 1918. In that year, following a relatively long cycle without any major outbreak and coupled with the influenza pandemic, 577 children's deaths were attributed to whooping cough. In the period following 1920, however, the trend changed and a very rapid decline began. The rate of this decline became very much slower again about 1937. Had it been possible to maintain the same rate there should theoretically have been no whooping cough deaths since 1943. There have been at least 55 deaths since then, however, 22 in 1945 and 23 in 1946.

A decline of mortality has, of course, occured in many areas of the United States. A rapidly growing list of communities can report years with no deaths from whooping cough. Such is the case, for example, in Madison, Wis.; Grand Rapids, Mich.; East Orange, N. J.; North Arlington, N. J.; Evanston, Ill., and Newark, N. J.

The decrease in mortality began years ago and was already decreasing rapidly before effective vaccines were available. Detailed study of the New Jersey death rates does not reveal any influence attributable to the use of vaccines. To analyze this point further the Newark death rates were also studied closely. The curve of the death rates for New Jersey areas for the last ten years is shown in Graph II. As can be observed there is very little difference in the state and city rates. Statistical





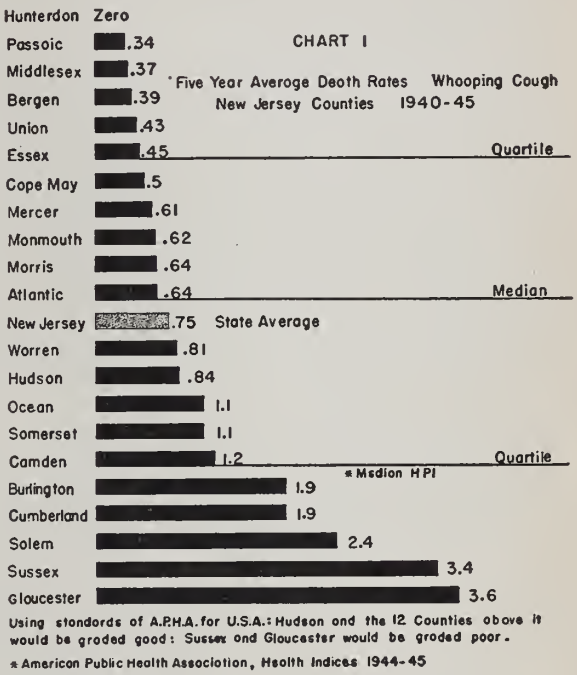
study of the decline during the period since 1940 shows that the differences between the two could have occurred by chance alone.

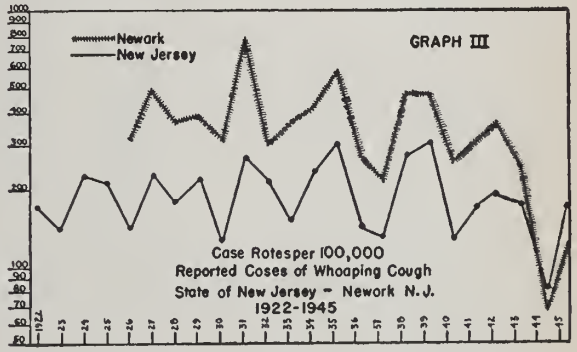
Five year average death rates by counties

* Director, Bureau of Preventable Diseases, New Jersey Department of Health, Trenton, N. J.

are illustrated in Chart I. The rates vary from zero to 3.6 per 100,000. The state rate is 0.75. This experience as a whole compares favorably with that in the United States and Canada, as recorded in Health Practice Indices,† since the median of the most recent volume of Health Practice Indices is a rate of 1.2. Two New Jersey counties, however (Gloucester and Sussex) would be graded poor by current American Public Health Association standards and thirteen would be graded good (Hudson, Warren, Atlantic, Morris, Monmouth, Mercer, Cape May, Essex, Union, Bergen, Passaic, Middlesex and Hunterdon).

During the spring of 1946, I had the opportunity of studying the reported incidence of whooping cough in more than a hundred communities in connection with the grading of Evaluation Schedules submitted to the American Public Health Association. It appeared that whooping cough morbidity might be coming under control in several areas. Study revealed a complex picture involving shifts in age distribution of the population and widely varying public health practices, but further evidence has continued to support the original hypothesis of the possibility of control. It is thus pertinent to examine the incidence of whooping cough in a large population (State of New Jersey) where, although vaccine has been used to a limited extent, the level of immunization relative to the state population is probably low. These data are outlined in Graph III and Table I. It will be noted that any trend would be in the direction of a slight increase. There has been a marked change in the total resident births during the past fifteen years which will be reflected in such a disease





† American Public Health Association: Health Practice Indices, 1944-45, 1790 Broadway, New York 19, New York.

TABLE I

FIVE-YEAR AVERAGE RATES PER HUNDRED THOUSAND REPORTED CASES OF WHOOPING COUGH SELECTED AREAS 1926-30 AND 1941-45

Areas	1926-30 Population	1926-30 Annual Average Cases	1926-30 Rates per 100,000	1941-45 Population	1941-45 Annual Average Cases	1941-45 Rates per 100,000
New Jersey (State)	4,041,334	6,768	167	4,160,165	6,970	168
Newark, N. J.	442,337	1,714	387	429,760	911	212
Grand Rapids, Mich.	168,592	407	266	164,292	271	165
Evanston, Ill.	63,120	380	602	65,389	78	119

NOTE: Comparisons should only be attempted between the two time periods in a single area. The data between areas are not comparable. In Grand Rapids, for example, an intense case finding program has been carried on during the latter period. Special case finding projects have been carried on in Evanston during varying periods.

as whooping cough. As a matter of fact, children under 15 comprised only 30.9 per cent of the population of New Jersey in 1940 in contrast with 36.1 per cent in 1930.

A more detailed study of the incidence of the disease is summarized in Table II using average age specific case rates of two five-year periods, 1926-30 and 1941-45. The rates have actually risen and the changes among the younger age groups are statistically significant. This increase probably reflects better reporting incident to more interest in the disease among public health officials, physicians and people, and to increased medical care and child health nursing services.

This rise, however, is *not* the situation in recent years in areas where active immunization programs have been carried on. The difference is tabulated in Table I. To study the decreases more closely, Newark data are subjected to the same analysis as the total New Jersey data above (Tables II and III). It will be seen that there has been a marked and significant decrease in the total case rate and in that of the age groups under one year and one to four inclusive, but not among the school age children. Newark has very active immunization, child hygiene and private pediatric services. An immunization campaign with the combined antigens was begun in 1940 and whooping cough vaccine was in use before then. The actual level of immunization attained is not available, but estimates [9] suggest that forty per cent of the preschool population may have been vaccinated between 1941 and 1945.

It seems evident from the magnitude of the decrease of whooping cough in the instances

TABLE II

AGE SPECIFIC FIVE-YEAR AVERAGE RATES REPORTED CASES OF WHOOPING COUGH—NEW JERSEY
1926-30 and 1941-45

Age Groups	1926-30 Population	1926-30 Annual Average Cases	1926-30 Case Rate per 100,000	1941-45 Population	1941-45 Annual Average Cases	1941-45 Case Rate per 100,000
Under 1	61,254	543	883*	47,789	529	1,107*
1 - 4	268,414	3,060	1,140*	208,475	2,865	1,375*
5 - 9	380,918	2,832	744*	280,722	2,947	1,050*
10 - 14	384,342	210	55*	337,776	499	148*
15 and over	2,946,406	123	42†	3,285,403	130	40†
TOTAL	4,041,334	6,768	167†	4,160,165	6,970	168†

* The differences in the rates between the two periods for these groups appear to have occurred because of some factor other than chance. The odds against their being due to chance are 3,142 to 1 for the group under one, and well in excess of a million to one for the others.

† The differences in the rates between the two periods for these groups could have occurred by chance (odds about one to one).

TABLE III

AGE SPECIFIC FIVE-YEAR AVERAGE RATES REPORTED CASES OF WHOOPING COUGH—NEWARK, NEW JERSEY
1926-30 and 1941-45

Age Groups	1926-30 Population	1926-30 Annual Average Cases	1926-30 Case Rate per 100,000	1941-45 Population	1941-45 Annual Average Cases	1941-45 Case Rate per 100,000
Under 1	6,830	197	2,884*	4,655	90	1,934*
1 - 4	29,320	872	2,974*	21,333	362	1,697*
5 - 9	41,150	606	1,462†	29,262	437	1,493†
10 and over	365,067	39	....	374,510	22	....
TOTAL	442,367	1,714	387*	429,760	911	212*

* The differences between the rates in the two periods for these groups appear to have occurred because of some factor other than chance. The odds against their being due to chance are well in excess of a million to one.

† The differences between the rates in the two periods could have occurred by chance alone (odds two-and-a-half to one).

of Evanston and Grand Rapids, that the decreases are significant. (See Table I) Both cities have achieved extensive immunization of the younger populations incident to research studies and in conjunction with the health departments. For example, Grand Rapids had secured the vaccination of 75 per cent of children entering school by 1944.

Another study was made of the data of East Orange, New Jersey, (Table IV), and the incidence of whooping cough was compared to that of measles. It will be noted that there has been a significant decrease in the incidence of whooping cough, but *not* in measles during the time periods studied. Although the use of whooping cough vaccine was not begun in the infant and preschool health centers until 1943, children of East Orange in general receive above average medical care, including preventive medicine. The public health services are well organized and effective. Although exact data are not available, there is every reason to believe that a high proportion of preschool children have been immunized against whooping cough early in life for the past five years.

It was suggested by Kendrick[8] that there had been a marked shift in the distribution by age of reported cases of whooping cough during the past seventeen years. Additional data on this point are presented in Table V. It can be seen that there have been extensive shifts in the distribution of cases by age in from 1-to-4-year age groups to the 5-to-9-year groups in those areas where an immunization program has been extensive. There does not appear to have been any significant change in the ratio of cases occurring under one year, although the absolute number of cases has decreased appreciably. The shifts in the cases in the total New Jersey experience may be due to population changes alone. It would appear that present immunization procedures protect children in the preschool period, but that this protection does not carry over or has not reached into the school years. More exact and extensive data regarding the relatively small shift, if any, among the under one year group are needed to evaluate this important item. Possibilities would seem to be: a lower level of immunization among those under one year, errors in reporting of age of cases, and better reporting among this age group.

These data suggesting that early immunization against whooping cough has been most effective in the preschool years and less so among the school age children should not surprise us. At least three factors are at work: *first,* it is doubtful if a significant number of children of school age now have been vaccinated since the vaccines have not been in extensive use for many years; *second,* there are the problems of decreasing protection from the immunization with the passage of time; and, *third,* increased exposure in the school experience. Experience over a period of years with the Schick Test and study of the epidemiology of diphtheria has indicated a similar occurrence. The use of a booster dose of diphtheria toxoid at the time of entering school to combat this situation, is a well established procedure. That it is equally indicated in whooping cough seems clear from the data presented, and, also, it seems reasonable to believe that its extensive use would be of very great aid in achieving control of whooping cough

TABLE IV

FIVE-YEAR AVERAGE RATES PER HUNDRED THOUSAND FOR WHOOPING COUGH AND MEASLES—EAST ORANGE, NEW JERSEY
1934-38 and 1941-45

	1934-38			1941-45		
Disease	Population	Annual Average Cases	Rates per 100,000	Population	Annual Average Cases	Rates per 100,000
Whooping Cough	68,482	358	523*	68,945	229	333*
Measles	.....	637	930†	.....	607	882†

* This difference appears to have been due to some factor other than chance. The odds of its being due to chance are well over a million to one.

† This difference could have occurred by chance alone.

morbidity. The use of a booster dose on the basis of exposure to the disease in instances where the exposed child has been vaccinated against whooping cough more than two years before the exposure, would also seem to be a sound procedure, particularly if controlled by a susceptibility test.[6]

SUMMARY

1. There has been a remarkable decrease in the mortality from whooping cough.

2. There has been a considerable, statistically significant, decrease in morbidity among preschool children from whooping cough in areas where extensive immunization programs have been carried on, but not in such larger areas as New Jersey as a whole. This decrease has not been observed in measles in at least one of the areas.

3. There has been a considerable shift in the age distribution of reported cases of whooping cough in the areas where there have been active immunization programs. The proportion of cases in the 1-to-4-age group has been lowered, whereas, the proportion among the 5-to-9-year group has increased.

CONCLUSIONS

1. The control of morbidity, as well as mortality, from whooping cough can be achieved. It is an entirely practical goal for all effective health programs.

2. Increased immunization programs, including the use of booster doses before entering school and on exposure are necessary to achieve this.

TABLE V
PERCENTAGE DISTRIBUTION BY AGE — CASES OF WHOOPING COUGH
SELECTED AREAS, 1926-30 AND 1940-45

Age Group	New Jersey				Newark, New Jersey			Grand Rapids, Michigan *			
	5 Year Total Cases	1926-1930 % of Total	5 Year Total Cases	1941-1945 % of Total	4 Year Total Cases	1926-1929 % of Total	1942-1945 % of Total	4 Year Total Cases	1928-1931 % of Total	4 Year Total Cases	1942-1945 % of Total
Under 1 yr.	2,713	8.0	2,647	7.6	789	11.5	9.8	124	8.1	104	10.9
1 - 4	15,302	45.2	14,324	41.2	3,489	50.9	39.6	822	53.6	382	39.8
5 - 9	14,161	41.8	14,735	42.4	2,423	35.3	47.8	549	35.8	415	43.3
Over 10 yrs.	1,666	4.9	3,144	9.5	157	2.3	2.5	38	2.5	57	6.0
TOTAL	33,842	99.9	34,850	100.7	6,858	100.0	3,642	99.7	1,533	100.0	958	100.0

* Figures do not include cases reported with unknown ages
1928-31 — 96 1942-45 — 0.

1. Weiss, E. S., and Kendrick, P. L.: Am. Journ. Hyg., 38:306, and Sako, W. et al.: Journ. Amer. Med. Assn., 127-379 (Feb. 17, 1945). Also see footnotes 3, 6 and 7.
2. Kendrick, Pearl, et al.: Paper read Nov. 14, 1946, to American Public Health Association.
3. Sauer, L. W.: Chapter on Whooping Cough in *Medical Clinics of North America*, Saunders, Philadelphia, January 1946. Also Lapin, J. H.: Journal of Pediatrics, 20:18 (1942).
4. Kendrick, Pearl L.: Am. Journ. Hyg., 38:193 (Sept. 1943).
5. Sauer, L. W., and Markley, E. D.: Journ. Amer. Med. Assn., 131:697 (July 20, 1946); also Felton, H. M., and Flasdorf, E. W.: Journ. Pediatrics, 22:259 (March 1943), and Mudd. Stuart: paper read Nov. 14, 1946, to American Public Health Association.
6. Felton, H. W., and Willard, C. Y.: Journ. Amer. Med. Assn., 126:294 (Sept. 30, 1944).
7. Lapin, Joseph H.: *Whooping Cough*. Charles C. Thomas Co., Springfield, Illinois, 1943.
8. Personal communication from Dr. Pearl L. Kendrick, Associate Director, Bureau of Laboratories, Michigan Department of Health, Grand Rapids.
9. Craster, C. V.: City of Newark, Health Report, 1945.

CONGENITAL DEFECT OF THE STERNUM WITH CONGENITAL HEART DISEASE *

Charles Hyman, M.D., Atlantic City, N. J.

Several cases of congenital defect of the sternum have been reported [1] in the literature. These patients reached adult life and were discovered only when hospitalized for some other condition. Various combinations of congenital heart lesions are constantly being added to the literature. However no instance of the co-existence of congenital sternal defect with congenital heart disease could be found. The following case is of interest because of this unique combination.

CASE REPORT

A child normally delivered of a healthy mother who had gone through a normal prenatal period, was found to have a pulsating mass in the low midsternal region. Examination disclosed that the heart was lying under the soft tissues because of a defect of the lower end of the sternum. Systolic and diastolic contractions could easily be observed at an estimated rate of 200 per minute. No murmurs were heard. X-ray examination of the chest suggested that the heart was larger than was to be expected in a newborn. The structure of the sternum could not be adequately visualized.

P-R Interval .08 sec.
Q-R-S Interval .04 sec.
Lead 1-14 mm S wave; small inverted T wave
Lead 11-Diphasic (Q-R) Q-R-S complex; ½mm elevation of RS-T segment; 2mm sharply peaked T wave.
Lead 111-14mm R wave; 3mm sharply peaked T wave; 1 mm elevation of RS-T segment.
Lead 1V-Not satisfactory for interpretation.
Right axis deviation.

Clinical diagnosis was congenital defect of the lower half of the sternum and congenital cardiac hypertrophy.

During the first 48 hours after birth there were three episodes of cyanosis. The child was kept in an oxygen bed and handled with extreme caution. Occasional mild cyanosis accompanied breast feedings. To prevent these attacks formula feedings were given while the baby remained in the oxygen bed. In an attempt to provide externally what was lacking in sternal protection to the heart, a breast plate of orthopedic felt was applied over the sternum and held in place with an elastic roller bandage. However the slightest increase in pressure with this appliance induced attacks of cyanosis. It was abandoned when it was noted that she did better without this protective dressing. In an attempt to bring the heart rate down to about 140, (the expected rate in a newborn) digitalis was given. The rate was reached in 72 hours. Despite all care the child died 22 days after birth in an attack of acute dyspnea and cyanosis.

AUTOPSY REPORT

The heart and pericardial sac lay immediately under the skin, apparently due to a defect in the sternum which measured only two centimeters in length. There was failure of the distal portions of the sternum to fuse; they were represented as two sided flarings along the cartilaginous processes of the ribs.

No fluid was found in the pericardial sac. The heart lay immediately beneath the skin since the sternum was not developed downward to cover it. It was reddish brown except over the auricles which were purplish red. The epicardium was smooth, transparent and glistening, and there was no epicardial fat. The myocardium was reddish brown and firm. The heart weighed 54 grams. The myocardium was markedly increased in thickness on the right side, measuring one centimeter at the right ventricle and 0.7 centimeters at the left. The mural endocardium was not thickened. The right ventricle had twice the capacity of the left and the left atrium about three times that of the right. Just beneath the line of origin of the tricuspid valve at the junction of the anterior and left lateral leaflet of the valve

* From the Department of Medicine, Atlantic City Hospital.

1. Hoffmeier, F. N.: Radiology, 27:493 (October 1936); Jordan, A.:Lancet, 2:877 (October 1935); Knight, Glen A. M., and Morley, George H.: Brit. J. Surg. 24:60 (July 1936) and Brink, C. J.: South African Medical Journal, 13:606 (August 26, 1933).

was a defect of the interventricular septum, oval in shape and 1.2 centimeters in length and 0.6 centimeters in width. The septum at this point ran from the right superior portion to the left inferior portion of the heart, and the long axis of the defect paralleled this. The defect opened into the left ventricle at a point 0.4 centimeters below the origin of the aortic cusps. With the aortic valve this defect formed a cylinder through which blood could pass directly from the right ventricle to the aorta. The foramen ovale was patent, measuring 1.4 centimeters in diameter. There was a strand of tissue a millimeter wide, running superiorly and inferiorly across the entire opening. The ductus arteriosus would have been patent except for the fact that there was a small well organized thrombus in its lumen.

Anatomic Diagnosis: 1—Absence of fusion of gladiolus and xiphoid process.

2—Congenital cardiac hypertrophy with right ventricular preponderance.

3—Interventricular septal defect.

4—Widely patent foramen ovale.

5—Patent ductus arteriosus.

DEVELOPMENTAL ANATOMY

According to Ballantyne [2] the heart is almost as perfectly developed at the beginning of the second month of pregnancy as it is a few days before birth. Knight and Morley [1] citing Keith [3] state that the sternum develops as a condensation of mesoderm on each side of the mid-ventral line, then represented by the primitive linea alba at the fifth week. These form the right and left mesenchymal sternal bars, which are continuous anteriorly with the bases of the ventral part of the shoulder girdle, and are situated over the pericardium between the mandible in front and the umbilicus behind. Fusion of these sternal bars commences at the midsternum at about the end of the sixth week; the caudal portions are kept apart by the protrusion of the heart and liver until union takes place by the tenth week. Chondrification and ossification then proceed.

COMMENT

In explaining congenital heart disease, opinion is divided between Meckel's theory of the embryogenic causes and the inflammatory theory of Cruveilhier and Lancereaux. Lloyd [4] states that neglected and improper prenatal care are causes of cardiac defects. Some observers [5] believe that syphilis is a major factor despite negative serology in parents and offspring. In this case there was no autopsy evidence of fetal endocarditis, no suspicion of faulty prenatal care, no parental clinical or serologic evidence of syphilis and no prenatal maternal infection of any nature. There was a distinct tendency towards obesity of the thyropituitary type in the paternal grandparents. The father exhibited some of these characteristics in a moderate way and the first child of these parents was a definite hypothyroid case. With this hereditary background the possibility of disturbed glycogen mechanism may be suspected as a cause of the generalized cardiac enlargement.

Sternal defects are said to be caused by pressure from the outside by the fetal head or by maternal organs. In other cases the pressure is from within the fetus as from relatively large fetal organs such as the heart or liver.

Since the heart is practically perfectly developed [2] at the fifth week and the caudal portions of the sternum do not normally close until the tenth week,[3] it can be theorized that normal fusion of the lower sternum was prevented by the congenitally enlarged heart which needed this additional space to function.

2. Ballantyne, J. W.: Antenatal Pathology, Edinburgh 1902, p. 370.

3. Keith, Sir A.: Human Embryology and Morphology, (5th ed.) 1933, London, p. 472.

4. Lloyd, H. J.: Minnesota Medicine, 19:706 (November 1936).

5. Prospect, E.: *Contribution a l'etude de diagnostic des maladies du coeur*, These de Paris, No. 434, 1921.

2807 Pacific Avenue

GENERAL SURGERY IN PSYCHOTIC PATIENTS

John F. Kustrup, M.D., Trenton, N. J.

Presented herewith is a picture of the general surgery done at the New Jersey State Hospital for the four year period ending in May 1946. During that period there were 2100 surgical consultations and 700 operative procedures of all types.

A definite program was followed in order to obtain maximum efficiency from our limited wartime personnel. It was as follows:

All non-emergency consultations were held on a fixed day every week. This day was set aside also for such diagnostic procedures as cystoscopic and sigmoidoscopic studies and minor surgical problems which did not require too much time. On completion of the surgical clinic, all x-rays ordered the previous week were reviewed.

Another day was set aside for operations requiring anesthesia. Emergency consultations and operations were done as the occasion presented itself.

Elective preoperative cases were brought to the surgical clinic for a physical recheck preceding the surgical procedure, and after permission for surgery had been obtained.

Postoperative cases were seen every other day by the attending surgeon and daily by the resident physicians, who kept the surgeon advised of important changes in the condition of the patient.

ANESTHESIA

Ninety-five per cent of the surgery below the diaphragm was done under spinal anesthesia. Procaine was the preferred agent. Dosage varied from 50 milligrams for average proctologic cases to 200 milligrams for gynecologic and upper abdominal surgery. In prolonged operations continuous fractional spinal anesthesia was used.

If the dosage of procaine was insufficient, the spinal anesthesia was supplemented by nitrous oxide and ether, pentothal-sodium-02 or curare which we added to our anesthetic armamentarium in 1946.

Nervousness was not a contraindication to spinal anesthesia, but fretful patients received enough general anesthesia to supply good sedation.

Postoperatively, all patients were restrained, but despite this precaution, some would break strong restraining ties, get out of bed and walk to the bathroom. None of these complained of headache.

THYROID SURGERY

Thyroid surgery was done under nitrous oxide-oxygen-ether anesthesia but in our last three cases we used sodium pentothal.

When the manic condition of the patient interfered with a satisfactory basal metabolic test, this procedure was dispensed with, the patient was given iodine and phenobarbital and the pulse rate was used as the index to determine when the patient was ready for surgery. The manic or depressed states not of thyroid cases alone, but of all patients appeared improved after surgery. The most surprising observation was the cooperation and gratitude of these patients for the care given them. In one case of total calcification of the thyroid gland which was preoperatively thought to be a malignancy, the patient who had not talked above a whisper (and who actually hardly talked at all) heard me say: "here is one patient on whom we'll never know if the recurrent laryngeal nerve was permanently damaged because she won't talk". The patient glibly said "Oh, yes I can, doctor". She has been discharged recently as cured.

ABDOMINAL SURGERY

In abdominal surgery we encountered the usual gall bladder, pancreatic and gastrointestinal pathology found in any hospital. The one additional group of patients seen were those who had ingested foreign bodies. If these caused no symptoms the patient was watched by serial x-ray studies. In practically all cases, the foreign body was eventually passed without difficulty. Sulfasuxidine was given to all persons with open pins or sharp objects in the gastrointestinal tract.

Our prize case was that of a male whose stomach, on gastrotomy, presented us with a carefully torn up rubber bed sheet, two packs of gauze, four pieces of metal (quarter inch in diameter and eight inches in length) and two pipe stems. We even found a silver dollar impacted in the fixed portion of the sigmoid colon. He made an uneventful recovery only to die a year later following a perforation caused by another ingested foreign body.

We performed 103 herniorrhaphies following the Stewart-Lee Halstead technic. At first, we used catgut and later silk as the suture material. The only recurrence was in an employee on whom a bilateral herniorrhaphy was performed. Recurrence was on the side repaired last, due undoubtedly to too much tension on the suture line.

Our gynecologic surgery included operations for carcinoma of the uterus and ovaries, leiomyoma of the uterus, prolapse, pelvic relaxations and bladder fistulae. We also encountered a few cases of lymphopathia venereum and one granuloma inguinale.

Prostatic surgery was done in one stage after adequate catheter drainage and irrigations, usually under procaine spinal anesthesia, 100 milligrams.

Hemorrhoids, fissures, fistulae and rectal prolapses were numerous enough to stock a museum of proctology.

TRAUMATIC SURGERY

Traumatic surgery was often needed for treatment of self inflicted wounds due to gouging out of tissue with sharp instruments, repairing the scalp in patients who ran head on into corners in a "butting goat-like" fashion, and laparotomy for investigating damage done by instruments improvised by patients from such objects as bed springs.

One patient (a physician) stabbed himself in a site which, he stated, hurt most. On exploration, no damage was visible due to the bed spring but extensive postoperative adhesions were found, causing marked distortion in the anatomic arrangement of the stomach and colon. Since correction of this, he has had no pain and in the past year has been entirely free from his addiction to alcohol and narcotics.

Fractures of the hip were common. These were due either to shock therapy or to falls resulting from tripping or being pushed by another patient. Most of the patients were elderly and had a marked osteoporosis so that the muscular pull caused by electric shock was sufficient to cause the break.

Of the hip fractures, twelve were due to shock therapy. This is a small ratio when one considers that 800 cases were treated by shock therapy in that time.

Intratrochanteric and intracapsular fractures were about equal in number.

At first the only means of treatment we had was to reduce the fracture and apply a body cast. In the first group treated our mortality was 80 per cent (four out of five cases) and the one who survived had a complete absorption of the neck. These patients could not be controlled. They would defecate and urinate over the cast, developed large decubitus ulcers and actually rotted in their casts.

We decided to stop using body casts entirely. In 1944 we began the use of Well leg traction for intratrochanteric fractures and Smith Peterson nail internal fixation for intracapsular fractures. In the latter part of 1944 (after hearing of the fine results in the treatment of arteriosclerotic psychosis by shock therapy) it was decided to try it here. In the three months which followed our surgical department was very busy. We soon used our Roger Anderson traction splints, improvised a modified Well leg traction that consisted of a board placed obliquely between the two legs and one between the feet. These were incorporated in the two leg casts. When more traction was needed, the obliquely placed board was split from the cast and moved down on the good leg obtaining an increased pelvic tilt. This took too much time and led to the invention of a turn buckle traction bar which looks very much like a skate clamp. This is placed obliquely between the good leg and the fractured leg and traction and counter traction are obtained by merely turning a turnbuckle screw with the thumb and index finger.

This proved more satisfactory than Roger Anderson traction. It is simpler, more economical and did not require the use of a Steinman pin through the tibia.

Our intracapsular fractures which were nailed progressed so well and required so much

less nursing care than those with Well leg Traction that we looked for a similar treatment for our intratrochanteric fractures. The Neufeld nail was our solution.

In May 1946 our treatment for fractures of the hip was:

(1) Smith Peterson nail for intracapsular fractures.
(2) Neufeld Nail for intratrochanteric fractures.
(3) The author's Well leg traction for any case properly reduced where ulceration of the leg or infection contraindicated the use of treatments 1 and 2.
(4) Roger Anderson Well leg traction for intratrochanteric fractures where internal fixation was contraindicated and no ulcerations of the leg were present.

Why did fractures occur in some of the patients, when others, in falls and after shock therapy, sustained no fracture?

I think that malnutrition, possibly with hypoproteinemia as one of the factors, was responsible. A serum protein determination was made on the fifteen fracture cases in the surgical wards in 1946. All had a hypoproteinemia with a serum protein variation from 4.16 to 6.9 grams per cent. A secondary anemia was present in this group.

Of a similar group picked at random from other parts of the institution, only one showed a hypoproteinemia and anemia. Though the number is small it supplies food for thought. We could conclude that in those cases with hypoproteinemia and anemia, fractures are more likely to occur; and that therefore shock therapy is contraindicated until the nutritional state of the patient is improved.

I believe that should be adhered to as rigidly in the performance of and preparation for shock therapy as in the preparation for a major surgical procedure.

During the war we were supplied with human R.B.C. extract for the purpose of promoting more rapid wound healing in old ulcers and infected ulcers. Our conclusion is that there is no agent other than cleanliness and improvement in circulation which brings about more rapid granulation and healing in these cases.

In some of our clean ulcers, of recent origin, the use of human R.B.C. did appear to hasten granulation of the wound. It also served as a good cement substance in the fixation of Thiersch grafts.

In conclusion, general surgery at the New Jersey State Hospital of Trenton, differs in no way from that in any other good hospital. It does afford the surgeon the advantage of watching his patient over a long period of time and permits him to evaluate his results.

1416 South Broad Street

GENERAL HAWLEY TO SPEAK IN NEWARK

Announcement has been made that Major General Paul Hawley, Chief Medical Director of Veterans Administration, will be the principal speaker at the institution of the Physicians' Post of the American Legion which will be held at the Hotel Sheraton, (Hill Street) Newark, at 8:30 p. m., Friday evening, September 27, 1947.

Veterans of either world war who are now physicians and who were honorably separated from the service are eligible for membership in this Post. Those who join prior to the institution on September 27 will be considered charter members. Communications should be addressed to Physicians' Post, Box 864, Newark 1, N. J.

VASCULAR NEVI AND THEIR TREATMENT *

A. J. DELARIO, M.D., Paterson, N. J.

Vascular nevi are common lesions, seen frequently by the general practitioner. Treatment often depends on the type and site of the lesion. Early treatment will greatly improve results. An understanding of nevi is important too, because occasionally they undergo malignant degeneration.

Vascular nevi briefly are simple angiectatic dilatations of pre-existing vascular tissue, with or without proliferation of new vessels. In telangiectases and port wine stains there is primarily a dilatation, and in the cavernous hemangiomas there is in addition a proliferation of new vessels. The major types are described below.

TELANGIECTASIS

A telangiectasis is a vascular dilatation. It is a symptomatic manifestation in rhinophyma, rosacea, angiokeratoma, morphea, roentgen dermatitis and in xeroderma pigmentosum. Most often it is found on the flushed areas of the face and on the lateral surfaces of the nose. The lesions are tortuous bright red to reddish blue lines level with the surface of the skin or slightly elevated. Telangiectases are seen commonly in older women about the legs, sometimes associated with varicosities. Occasionally they occur in pregnancy.

Nevus araneus or the spider nevus is a common vascular dilatation consisting of a central tumor with numerous capillary radiations. Sometimes seen in newborn infants, it is most common on the face in children. Lesions are dark red, with slightly elevated centers. The growths usually are solitary (or few in number) but in some cases may be generalized. The generalized cases are often found in more than one member of a family. In some cases they have been associated with syphilis. Although this nevus may disappear spontaneously it is more likely to persist for years and may become permanent.

The pulsating *nevus araneus* is occasionally seen in telangiectases occurring in liver cirrhosis. It may be present on the face, neck, shoulders, anterior chest wall and hands. Sudden eruptions are occasionally seen heralding beginning liver decompensation with disappearance during amelioration. *Multiple stellate nevi* are recognizable as little specks with pin head sized slightly prominent red centers from which star-like fine vessels radiate. In some of these structures a central pulsation is noticeable by the palpating finger.

Williams and Snell[19] report that the blood vessel tumors appear first and frequently antedate the hepatic disturbance by many years. With the onset of the hepatic disease the cutaneous lesions often increase rapidly in size and number. It is not unusual to observe partial regression of the angiomas with improvement in the hepatic condition. The lesions are in effect both angiomas and telangiectases, the former being primary and the latter secondary. A hereditary tendency is present in some cases.

Stellate nevi are coils of arterial vessels in direct connection with typical normal subcutaneous arteries. The vascular coils continue into intermediary vessels and dilated capillaries, which partly encircle the coils, partly radiate beneath the epidermis, thus forming the telangiectatic wreaths of the nevi.

Hereditary hemorrhagic telangiectasis (Osler's disease) is an inherited anomaly. The lesion appears at puberty. Telangiectases and angiomas occur on the face, nasal septum, buccal mucosa, tongue and even on the internal organs. Rupture of these red or purplish vascular dilations occasionally gives rise to serious hemorrhages.

Francke's striae. Telangiectases of red wine color near the lower cervical spine, posteriorly unilaterally or bilaterally are found in about 45 per cent of patients with pulmonary tuberculosis.[16]

Senile angiomas are small pin point to pea size lesions. They are seen in any part of the body and many are found in each individual. These are really circumscribed dilatations of

* From the Department of Radiology, St. Joseph Hospital, Paterson, N. J.

the capillaries of the papillary layer. There is no formation of new vessels.

Nevus flammeus (Port wine mark or nevus vinosus). Although port wine mark has been classed with the cavernous hemangiomas, it differs from them in structure. These nevi are really telangiectases containing varying amounts of pigment. In the upper layer of the corium appear large numbers of newly formed capillaries and great dilatation of the pre-existing ones, particularly those of the venous type. Occasionally these changes are accompanied by an increase in the number and dilatation of the deeper vessels. These nevi are in the superficial layers of the skin. They are usually flat and flush with the surrounding skin. Most of them occur on the head or neck and remain unilateral. They are covered with a thin layer of epithelium and have within them little or no hair. Because of the thin skin tissue covering, the closely developed vascular channels give a red-violet color to the lesion. The nevus flammeus is present and fully developed at birth. It does not grow any larger. Some may not be prominent, and the color may not be too evident. These occasionally disappear without treatment. Lerner[7] says they never regress spontaneously.

Angioma serpiginosum. Hutchinson[5] described a vascular nevus which is characterized by multiple telangiectases which may arise from a previous congenital lesion. The primary lesion is a small reddish angioma. The mode of extension is by occurrence of satellite lesions which later coalesce to form large patches. The disease extends slowly. It tends to progress at its edges, and whiten in its center.[9] This is a simple abnormal growth made up of capillaries, endothelium and connective tissue.

The Nevus anemicus is characterized by numerous, irregular-shaped pale or white areas of the skin containing less blood than normal. The vessels are slightly narrowed histologically.

Strawberry hemangioma. Strawberry birthmarks are raised, cavernous hemangiomata. Each is a rapidly growing, elevated plateau or a sponge-like lesion, occurring on the surface in any part of the body, usually on the face. In the corium or in the sub-cutis newly formed dilated vessels separated by a narrow band of connective tissue are found. The vessels are lined with flat, occasionally hypertrophic, endothelial cells and are filled with blood. Many are thrombosed. Veins, capillaries and arteries are involved in the process. The connective tissue also shows signs of active proliferation. The latter in some cases compresses and destroys the angiomatous spaces resulting in self healing. Occasionally the lymph vessels and spaces may be involved. As a result of hemorrhage due to injury we find collections of plasma and lymphatic cells as a reaction. A birthmark with large blood spaces and little connective tissue will be most compressible and one with small spaces and much connective tissue will be relatively non-compressible. This is important in selecting the form of therapy.

Strawberry nevi are present at birth or appear within the first few weeks after birth. They are usually very small when first seen. They grow rapidly the first few months after their appearance and then stop their rapid growth within a year. After this they grow at about the same rate as the neighboring tissue. Lister[8] says that after this rapid growth they tend to regress and disappear by the fifth year. Those that grow fastest are most likely to regress.

Cavernous hemangiomas are capable of great destruction of tissue, and when on the face destroy the features. They may eat out great areas in other places, for example the breast and vulva. When these superficial cavernous hemangiomas are present with deep cavernous hemangiomas as they usually are, destruction is greater. There is also a great danger of bleeding.

I have seen a baby become almost exsanguinated from the scratching of a pin head size lesion on the eyelid. The lesions should be treated early when they are very small. Then they are most radio sensitive and at their greatest and most active growth period.

When the dilatations of the blood vessels are sack-like in character we have a *hemangioma cavernosum.* These are usually deep. They may be present in the subcutaneous regions, where they are raised, bluish in color,

and compressible. They may occur in muscle. Here they are circumscribed or diffuse. X-ray examinations may show a ring shadow (phlebolith) as the result of calcification in some of the blood vessels. Symptoms are weakness, a tendency to tire easily, later functional impairment and even contracture deformities. Pain is an early symptom.

An uncommon form is *sinus pericranii* which is a hemangioma of the pericranium communicating with the dural sinuses through one or more abnormal openings through the skull. Sinus pericranii appears as a soft, compressible, fluctuant swelling which increases in size when the venous pressure is increased (as in crying, straining, or when the patient assumes a posture with the head down). A diagnosis of meningocele is frequently made when there is no discoloration. Sinus pericranii gives few symptoms, but moderate pain and vague cerebral symptoms have been recorded. Location of sinus pericranii in order of frequency is over the forehead, along the sagittal sinus, and over the occiput. Abnormal openings in the skull, demonstrated by radiologic examination, are helpful in making the diagnosis.

Cavernous hemangiomas may occur in the gastro-intestinal tract. They manifest themselves by repeated intestinal hemorrhages usually beginning in infancy. Radiologic examination is of value if the lesion is pedunculated or contains phleboliths.

Deep cavernous angiomas have been found in bone, especially in the bodies of the vertebrae. X-ray shows longitudinal stria absorption. Patients complain of pains in the back and weakness.

Deep cavernous hemangiomas develop slowly and may seriously alter tissues by causing hypertrophy of other tissues near by, or destruction by altering the blood supply. Occasionally they cause hemi-hypertrophy of the face or body, part or the whole of an extremity. They are painful.

Occasionally both superficial and deep cavernous hemangiomas are found together. Both may be found in association with lymphangiomas.

Cavernous hemangiomas are often associated with lipomas or with neurofibromas. Frequently other developmental defects are found along with the hemangiomas, for instance chondromas and dyschondroplasia.

Newcomet,[12] in 506 cases of vascular nevi found 349 in females, 157 in males. They are unusual in the colored race. He listed 422 capillary or cavernous hemangiomas. There were 14 lymphangiomas and 70 fibroangiomas, including the various forms of moles. In Newcomet's series, the commonest sites were the face, the head, the arms, the leg and the neck in that order.

Malignant Hemangiomas. Occasionally hemangiomas that look histologically benign may metastasize. They are radio sensitive. Robinson and Castleman[14] reported a case in a girl 18 years of age in which the lesion first started in the breast.

One of my cases of port wine birthmark was in a Negro, age 40, who developed several malignant nodules which showed angio-sarcoma.

Another patient 60 years of age developed a lesion on his thumb that had all the appearance of a hemangioma. It had appeared about six weeks previously possibly after a slight injury, and was about five millimeters in diameter. It was removed by electro-coagulation, but it promptly returned. After the second electro-coagulation it disappeared and has not recurred since. That was over fifteen years ago.

The more malignant hemangiomas are rare and, when they do occur, practically always arise from and affect internal organs.

Endothelioma is a proliferation of lymphatic or vascular endothelium. The lesions may be associated with trauma, and are of pea to orange size; dark red, fairly soft. They may ulcerate and bleed profusely. They seem to arise from capillary forming material. Undifferentiated polymorphic cells in whorl arrangement with vacuoles in the cytoplasm, arrange themselves in rows and form endothelial lining of blood spaces. The lesions may be benign or of only local malignancy. Malignant angioblastomas are with difficulty distinguished from reticulo-endothelial blastomas.

Lymphangioma. In lymphangiomas as in hemangiomas, there may be dilatation of the

lymphatic spaces as well as a growth of new lymphatic vessels. They are similar to cavernous hemangiomas both histologically and in other characteristics. They are usually found at birth and grow slowly. They respond (as do the cavernous hemangiomas) to various forms of treatment. As in the case of hemangiomas, treatment must be started early. A few of them are malignant from the beginning. If left untreated some assume sarcomatous characteristics later in life.

Lymphangiectases are simple dilations with or without skin vesicle formation, and may involve the superficial or the deep lymphatics, or both. They occur usually as the result of lymphatic obstruction over a period of time.

Cystic lymphangioma or hygroma is usually congenital in origin and affects the lower side of the neck, occasionally extending into the mediastinum. The tumors are thin walled, containing lymph, and lined with endothelium. They usually appear in the first two years of life but may develop anytime. They grow rapidly.

Lymphangioma simplex. These small, circumscribed, compressible tumors of old or newly formed vessels filled with fluid are usually present in and about the mouth and genitalia. The lesions are whitish or pinkish in color, translucent and irregularly grouped.

Lymphangioma circumscriptum — (Cavernous lymphangioma) is characterized by localized eruptions of thick walled, pin head to pea size, opalescent vesicles. The groups are few, (one to three in number) usually on the thighs, the upper arms, and the mucous membrane of the mouth and tongue. Patches are of various shapes and sizes about eight to ten centimeters, in diameter. As the lesions get older they become rough, crusted or verrucose. They occur early in life and are usually persistent. The cause is believed to be deep lying obstruction.

The names "simplex", "hypertrophic" and "cavernous" depend upon the structure. In the first the vessels are small and uniform in caliber; in the "hypertrophic", the proliferated cells are massed together; in the "cavernous", dilatation is the outstanding feature. Combinations in a single specimen are common.

ETIOLOGY OF VASCULAR NEVI

Telangiectases are supposed to be due to mechanical, chemical, toxic and neurogenic causes.

Injuries that have an enfeebling effect on blood vessels will cause more marked changes in the smallest vessels, which may eventually result in telangiectasia.

The long continued influence of agents capable of injuring the skin is seen in the case of sunlight, which is responsible for many photodermatoses causing telangiectases (xeroderma pigmentosum). Telangiectases are seen caused by roentgen and radium irradiation. They are seen to follow various atrophies of the skin.

The influence of various hormones upon telangiectatic growth accounts for the development of such lesions incident to pregnancy, rosacea, and chronic erythrocyanosis.

According to Lewis,[9] the effect of the histamine substance also manifests itself in the mechanism of the telangiectasia. In many individuals, the vasomotor-capillary system is already primarily insufficiently developed. This results in the occurence of telangiectases, either directly, or indirectly via the vegetative nervous system; through hormones, lack of oxygen, carbonic acid, toxic influences, physical irritants (light, roentgen rays).

ETIOLOGY OF CAVERNOUS HEMANGIOMAS

The Fissural Theory: Because the majority of hemangiomas occurred in the neck and side of the face this theory was formulated by Virchow, who believed that the fetal clefts are related, not only to disturbances of normal skeletal development, but also to skin malformations. The vessels often develop along these clefts and this increased development at these richly vascularized sites, is thought capable of producing a nevus owing to the mild irritation which takes place.

Intra-Uterine Pressure Theory. Unna[17] propound this theory. He believed that vascular nevi were caused by pressure during late fetal life, when the face and occiput come into intimate contact with the bony structure of the maternal pelvis. The pressure thus exerted would tend to produce local compression

anemia with subsequent paralytic anemia, and ultimately lead to nevus formation.

The intrauterine pressure theory has been rejected by Siemens, who found instead a predilection for the median line. Further, in twins, the first-born twin was affected in some cases less, in others more, and in still others the same as the last born.

Cohnheim's Theory. Ribbert's thoughts on the etiology of vascular nevi are based on embryonic germinal sequestration (Cohnheim). Embryonal buds are assumed to detach themselves from germinal areas to lead an independent existence. Ribbert believes that all vascular tumors are due to a congenitally disturbed development in which a circumscribed area of a small artery may grow spontaneously and unrelated to the surroundings, or may lose the relationship at a later period. This view appears to be supported by the lobulated structure and sharp delimitation of many angiomas, as well as by Ribbert's experiments. In these experiments he injected simple and cavernous angiomas and was able to fill these growths but not the adjacent vessels. From this he concluded that there is no communication between the angiomas and the surrounding capillary network but that to begin with, they develop from an independent germ which has detached itself from its normal relationship.

Neurogenic Theory. One of the most popular hypotheses is the neurogenic theory of Baerensprung, first enunciated in 1863. He observed that nevus unius lateralis is distributed in segmentally innervated cutaneous areas and ascribed this systematic arrangement to pathology or prenatal injury of the spinal ganglia. This appeared to be supported by the unilateral distribution of these nevi and their sharp delimitation by the median line, by their distribution along the peripheral expansion of spinal nerves.

Infection: Some authors believe that infections or toxins are the exciting cause in the production of certain nevi and that nerve lesions merely render the soil suitable for infection.

The germ-plasm theory of Meirowsky[11] maintains that the disposition to nevus formation is always present in the germ cell, that nevi are therefore idiotypic formations, and that embryonic environmental influences are not of decisive importance in their production. Thus, the designs of the systematized nevi are seen as remnants of the skin patterns of bygone conditions or as an atavistic reversion to such conditions. Scholtz[14] is of the opinion that only those cells which are not yet fully differentiated are present in the affected skin area, and that there may originate from these skin areas any type of nevus or any type of tumor.

Conclusion: Apparently nevus formation may result from diverse exogenous and endogenous factors which affect the cells of the skin, especially during the embryonic period. Stimuli or injuries which operate at a very early stage may produce relatively large nevi, usually at birth, and they will be associated with malformation of the substrata, pigment, hair and glands.

Yamada[20] found that hemangiomas do not wheal with histamine and he thus believes that local aplasia of the vasoconstrictor nerves is present.

Extensive hemangiomas of the skin are frequently associated with hemangiomas of the nervous system.

Glaucoma and extensive nevus flammeus are known to be related.

The etiology of lymphangiomas follows along the same lines as in the case of the angiomas. Deep lying lymphatic, or conjointly venous and lymphatic obstruction whatever the primary cause, is the first of a chain of events which result in lymphangiectases and lymphangiomas.

TREATMENT OF VASCULAR NEVI

The treatment of vascular nevi depends upon the type of nevus present, its size, its location and its duration. Often different forms of treatment might be just as efficient on the same type of vascular nevus.

The treatment of telangiectases requires great care. Suitable cases must be selected, preferably those having the larger vessels. They may be destroyed by electro-coagulation, carbon dioxide snow, sclerosing solutions, and occasionally by surgery. The smallest ones are best left alone. Removing the underlying cause may cure the telangiectases. In one case of telangiectasis associated with sinus trouble,

the telangiectasia disappeared as soon as the sinus trouble cleared up.

When electro-coagulation is used, the point of a needle electrode is inserted to the depth of about one millimeter and the current applied for a fraction of a second. The effect is to destroy the vessel at that point. A point four millimeters further along the vessel is next treated in the same way, and so on, the number of punctures required for a given vessel depending on its length. About 40 or 50 punctures may be made at a sitting. The treatment is followed by slight swelling and erythema, but this subsides in less than 24 hours. Cosmetic result is good. Local anaesthesia is used.

For early rhinophyma and for persistent rosacea of the nose unassociated with visible telangiectases, freezing is often satisfactory. Carbon dioxide snow is applied evenly for two seconds on the affected area. The treatment may be repeated after a month, but the application should never exceed more than two or three seconds, and should never be of sufficient strength to cause the slightest scarring.

For the induration and telangiectases resulting from radiation dermatitis, alpha ray ointment is used, 100 electro-static units or .0364 millicuries weekly for eight hours. The number of weekly treatments depends upon the size of the lesion. The beta and gamma rays of radium as a rule do not give good results in any form of telangiectases.

Occasionally a drop of 5 per cent quinine urethane solution may be injected beside the ectatic vessel.

Central stellate angioma swelling may be destroyed easily with a galvanocautery; a needle electrode is inserted and heat applied for about one second. Diathermy is also effective, a needle being employed as an electrode and current applied for one or two seconds, according to the milliamperage. In both technics, results are generally good. In the absence of a well defined central swelling, several points are treated.

Hereditary hemorrhagic telangiectasis (Osler's disease), the Francke's striae and the nevus serpiginosum should be treated only if danger of trauma and bleeding exists. Electro-coagulation, dry ice, injection methods and surgery might be used.

The senile angioma is practically always small and best left alone unless there is danger of trauma and bleeding. Then it can be electro-coagulated. Carbon dioxide ice can be used for fifteen seconds with moderate pressure. The lesion will turn white with the dry ice and a small hole or pit will be seen at the point of pressure immediately after the treatment. Just enough time and pressure was used if the lesion will regain its original shape, and color in three to four seconds. If it takes much longer to defrost, expect a moderate reaction from the treatment. Then use less time and pressure for your next case or treatment.

TREATMENT OF PORT-WINE STAIN (NEVUS FLAMMEUS)

Excision by surgery or electro-coagulation is indicated for small lesions. *Surgery* is the method of choice for large nevi on the scalp, trunk and limbs where the operative scar will not be cosmetically important. *Dry ice* has given good results on small lesions, and even on large ones if applied to small areas one at a time. Use a dose of fifteen to twenty seconds with light pressure. *Treatment by ultra-violet* should start early, that is, within the first few months. Good results may be expected with the port-wine stain if treated by x-ray and radium radiation within the first year of life. Beyond the first year they are radio-resistant (Hodges[4]).

Grenz rays in the order of two angstrom units have been used with advantage. It has been found that the Grenz rays are efficacious in improving the cosmetic result with marked bleaching of the birth-mark. . . . In the average case Kalz[6] applied Grenz rays in a single dose of from 800 to 1,000 roentgens with a total dosage of 10,000 to 12,000. The factors he used are 12.5 kilovolts, 15 milliamperes and .0026 aluminum filter. Distance was seven centimeters. Surrounding areas are protected by barium zinc paste. When the lesion is located near the eye or in the anterior portion of the neck, diminished dosage is used, not surpassing 700 to 800 roentgens per treatment,

with a total of 7,000 to 8,000. These may develop telangiectasia if treatments are too large. Large nevi are best treated by subdividing into smaller fields, diminishing the dosage to each field twenty per cent, while smaller nevi may be treated with twenty per cent above the average amount. In children, Kalz[6] uses a single dose of 800 roentgens per treatment with a total of 8,000. Never use more than 8,000 roentgens. For deep-seated lesions an additional filter of .001 mm. aluminum is recommended.

Prognosis is best in small children and is better in light colored than in deep red lesions. While pigmentation may disappear spontaneously, the development of a small dark brown patch is a serious symptom, necessitating the discontinuance of Grenz ray therapy.

Kalz's experience[6] has been limited to eight cases, all in adults, in whom the birth-mark had been present for many years. With therapy extending over three to nine months' time, treatments given every two weeks, lesions have shown marked bleaching and in the main, results have been satisfactory.

TREATMENT OF VASCULAR NEVI OF THE CAVERNOUS TYPE

All these lesions should be treated early in life, i. e., within the first few months.

The treatment of small lesions in early life is a simple matter. Large lesions in older children and in adults may necessitate much more intensive procedures, possibly involving risk of permanent disfigurement. A small pea size lesion which responds with almost any method if treated early will be many times larger in a few months, will cause a great deal of deformity and will require numerous treatments. Some types of nevi are aggravated by mechanical irritation, injury or infection. This is an additional reason for treating them at an early age when the patient can be kept under proper control.

These lesions bleed extensively when scratched and if this occurs at night when parents are asleep the baby might become exsanguinated.

The treatment in cavernous hemangiomas depends upon size, location and duration. Sometimes more than one type of treatment will give the same results. Usually these hemangiomas are multiple, occur in different parts of the body, are different in size and require different methods. It is always best to give treatments slowly. Never treat a lesion with a modality which, when previously given failed to improve the lesion.

TREATMENT OF THE STRAWBERRY MARK

This lesion is the most frequent of all vascular nevi. A number of them in different locations are likely to occur in the same individual.

Surgical Procedures. This is a good form of treatment when lesions are small and where a linear scar will not show. Small angiomas of the eyelids can be removed surgically and a linear scar parallel with the eyelid will not be disfiguring. Surgery can be used on angiomas on the trunk even if moderate in size where cosmetic result is not important. Surgical removal is accompanied by little bleeding. The panniculus of an infant, compared with that of an adult is proportionately so much larger than the frame, that it is possible to make excisions of sizable lesions in infants with results far superior to those obtained in adults.

Electro-coagulation can be used on small lesions where the entire mass is destroyed at one sitting. These lesions, (less than one centimeter wide) may occur on the scalp where radiation is contraindicated because of damage to the hair roots.

Small lesions in the mouth, on the lip and tongue can be burned off. Electro-coagulation rarely leaves a keloidal scar.

Carbon dioxide snow is used on small lesions especially on the body and extremities.

Solid carbon-dioxide snow is moulded into a stick just a shade larger than the diameter of the growth. The treatment causes obliterative thrombosis of the vessels in the angioma. The carbon dioxide snow may be mixed with a little acetone to form a semi-solid "mush" which is painted on with a brush. It must be remembered that penetration of cold depends not only on the length of exposure but also on the amount of pressure exerted on the stick. The amount of pressure should be just sufficient to hold the stick in place even when

the child moves slightly. The average time required for a simple, slightly raised mark is fifteen to twenty seconds. If the tumor is thick, as long as thirty seconds may be necessary. In a cold-sensitive child, even fifteen seconds will suffice to punch out a deep hole extending down to the underlying muscle. For this reason it is always best to try an experimental five second dose first. Then if nothing has happened, four days later the correct dose can be more safely applied. Immediately after application the solid snow left on the hemangioma evaporates, to leave a little condensed moisture on the surface. By the next day the area has turned a brownish-black. Gradually this slough dries to form a scab, which in many cases separates a week later to leave a superficial white pliable scar without the formation of a keloid.

The injection method of treating cavernous hemangiomas is effective whether the injection be made within the lumen of the vein (as in varicose veins of the extremities) or within the connective tissue between the veins as is done in hemorrhoidal vein injection. The most popular injections are: (a) 20 per cent solution of quinine dihydrochloride and urethane diluted with equal parts of 2 per cent procaine hydrochloride (with ephedrine). (b) sodium morrhuate in 10 per cent solution, and (c) 20 to 40 per cent solutions of sodium salicylate.

A 20 per cent solution of quinine dihydrochloride and urethane diluted with equal part of 2 per cent procaine hydrochloride (with ephedrine) is painless and very effective. Inject the solution through a 26 gage short bevel "security-type" hypodermic needle along radial paths from a single injection site. A half cubic centimeter vaccine or tuberculin syringe allows accurate control of the solution injected. The solution is initially injected superficially throughout the mass. From 0.1 to 0.2 cubic centimeters are introduced at a time. Immediate blanching of the area occurs about the needle point. The needle is then advanced and the next injection is placed so that its area of blanching is continuous with the previous one. Multiple areas are thus injected until the entire lesion has been mottled with areas of blanching. The point chosen for injection often bleeds. A small gauze pad is applied firmly over the entire injected area with adhesive tape. The dressing is removed after from 48 to 72 hours and the area left exposed. If too much solution has been injected there may be central sloughing, but these areas generally heal. A month after the initial treatment the lesion should be blanching satisfactorily or there may remain scattered areas of angioma which are beginning to grow afresh. These are then injected individually and after another month has passed there should no longer be a tendency for growth and the mass should be replaced by a glistening naturally colored or light brownish epidermis, which in time becomes inconspicuous. From one to six treatments may be necessary.

Forty-four hemangiomas in thirty subjects have been treated as described all with excellent ultimate results. The ages were from 2 weeks to 3 years. There were no systemic reactions. The hemangiomas involved the scalp, forehead, eyelid, auricle, genitalia, lips, chin, cheek, neck, torso, extremities and buttocks. Several were sloughing spontaneously and infected before treatment was started.

Andrews[1] used the injection treatment in 52 cases. He found the quinine urethane (ethyl-carbonate) better than sodium-salicylate and sodium morrhuate. He gives the following technic for the use of quinine and urethane:

> Ordinary sterile precautions are observed. The area is painted with tincture of iodine and alcohol. The only equipment is a tuberculin syringe with a 25 gage hypodermic needle. This small needle enters the lesion easily, with the least possible tearing resulting in minimal bleeding or loss of solution on withdrawal of the needle. The solution is preferably diluted with an equal volume of sterile water. Each cubic centimeter of solution contains 0.1333 grammes of quinine hypochloride and 0.0666 grammes of ethyl carbonate before dilution. At first the amount injected into each lesion is no more than a few minims in any one area, the number of areas treated varying with the size of the lesion. Subsequently it is frequently advisable to use as much as a full cubic centimeter of the half strength solution or smaller amounts of the full strength solution in one treatment of an angioma.

After six years' experience with the injection method Andrew[1] has found that its ef-

fectiveness equals that of radium therapy. He says that it is a good method of treatment and that it will take the place of radium therapy. Perfect results were obtained in 70 per cent of the cases in which the angioma was treated by the injection of a sclerosing solution. In 10 per cent only a small remnant of the angioma was present at the cessation of treatment, and this was not sufficient to be objectionable. Slight and scarcely visible scarring occurred in 12 per cent of the cases in which such treatment was employed.

Dowling[3] uses the following technic:

> About one cubic centimeter of a solution of quinine bihydrochloride (quinine bihydrochloride, 0.266 gramme; urethane, 0.133 gramme; distilled water to 2 cubic centimeters) or a 10 per cent solution of sodium morrhuate is injected by a single puncture into various parts of the interior of the nevus. Occasionally more than one treatment is required, but as a rule a single injection initiates a progressive sclerosis which becomes complete in two to three months. If an overlying port wine or strawberry mark is present, it is necessary to treat this by other means, such as freezing.

Peyton and Leven[13] used the following method for the injection of sodium morrhuate:

> Sodium morrhuate in 7 per cent solution is used and the injection is made into a blood space. To get the point of the needle into these vascular spaces, (unless they are very superficial) it is necessary to plunge a short beveled needle well into, or through, the tumor and withdraw slowly with suction in the needle until blood is withdrawn. The space is then emptied as much as possible by elevation or compression, or both and the solution is injected in amounts varying from a few drops to 2½ cubic centimeters. Manual compression is maintained until a rubber sponge has been bandaged over the area to maintain compression.

In subcutaneous angioma, a burning painful sensation is sometimes felt. No slough occurred in any case in which the solution was injected into a blood space, but sloughing is avoided by injection of smaller quantities of solution and by the application of pressure.

In deeper cavernous hemangiomas the needle is plunged into or through the blood-filled tumor and then on withdrawing the needle with suction applied, blood is drawn when the point of the needle is within a blood space. The spaces are then emptied if possible by elevation or pressure and the solution injected. Sodium morrhuate (in amounts up to 3 cubic centimeters) is used. A pressure dressing is applied. Peyton[13] has used this treatment both with and without pressure and gets thrombosis without pressure, though the patient complains of pain when a pressure dressing is not applied. There is a tendency to overdistention of the hemangioma immediately after the injection is made. This is avoided by injecting smaller amounts of the solution and the application of a pressure dressing.

Peyton[13] has injected hemangiomas of muscle and treated one case of sinus pericranii with sodium morrhuate with good results. In his experience of several hundred injections of sodium morrhuate, Peyton has never seen a thrombosis extend beyond the lesion itself.

All of the successful results occurred when the injection was made into the blood spaces and the angiomas were compressible. Venetianer[18] uses both quinine with urethane and sodium salicylate in high concentration. The accent is not on coagulative effect but on promotion of constriction of the dilated vessel walls, the production of connective tissue and sclerosis. Sodium salicylate has an advantage over quinine urethane because it is better tolerated by children. Usually a 20 per cent solution of sodium salicylate is injected, but if the result is not good, the injection is repeated with a 30 to 40 per cent solution. Do not inject into the mass of the angioma, nor at a right angle. Try to place the sclerosing solution in the base of the tumor, to block the vessels leading to it. If injection is made into the mass of the tumor, the result will be necrosis with ugly shrinking scars. The needle should always be inserted a few millimeters away from the border of the mass, through normal skin, to avoid the oozing of blood. After injection, the tumor becomes pale and sometimes temporarily swells slightly. He uses 2 to 5 cubic centimeters, varying according to the child's age and size, but never exceeding 5 cubic centimeters.

If the result is not satisfactory, the injection may be repeated in one week. By this cautious treatment there is no necrosis or suppuration.

Boiling water has been injected in very large

cavernous hemangiomas and in some cases (because of their size) this is about the only treatment that is available.

RADIATION

Radiation therapy includes both roentgen and radium treatment. While cavernous hemangiomas may be treated by other methods, these other technics are painful, whereas application of radium is not. Radium is easiest to apply to an infant and gives a better cosmetic result. This is important when the lesion is on the face. Roentgen therapy gives good results, and in some cases this is about all that can be used, for instance in hemangiomas between the toes. Roentgen ray is not as easy to give as radium if the child cries and moves while being treated. In raying hemangiomas of the face, utmost attention must be paid to the sensitivity of the nose's cartilaginous frame and to the developing facial bones.

In giving x-ray to hemangiomas of the pelvis and extremities, it is necesary to prevent rays from reaching the growing ends at the joints and from reaching the gonads. In females, do not treat the breasts with radiation because destruction of breast tissue may take place. Use the other methods here. Hemangiomas of the hands are more radio-resistant than hemangiomas elsewhere.

The aim of radiation is not to destroy the angioma field, but to promote atrophy and obliterate the dilated vessels. The endothelial lining becomes vascularized and degenerated. There is an infiltration of the leucocytes into the vessel wall with ultimate stenosis of the lumen. The immature endothelium of the blood vessels is radio-sensitive, especially in the first year of life. This is another good reason why treatment should be started early. There is progressive replacement of the thrombosed vessels and tumor mass by apparently normal tissue.

For *radium treatment*, contact application is employed when the lesions are not more than three millimeters thick. For thicker lesions a distance of a full centimeter between the skin and the radium applicator is desirable.

The normal skin is shielded by lead 1/16 inch thick. A hole is cut into the lead shield just slightly larger than the skin lesion. The dose is from 1/4 to 2/3 of an erythema dose. Our applicator has the equivalent of two millimeters of brass filtration. I give about 25 milligram hours per square centimeter with the applicator in contact with the skin. If I use one centimeter distance between applicator and the skin, I double the dose. Do not treat more than four square centimeters at one time. Treatments are given at intervals of three months. It is rarely necessary to give more than three treatments. Do not repeat the treatment if improvement is continuing or if other reactive changes are present in the normal skin or in the lesion; especially if swelling and tenderness are present. Desquamation is a sign of over-treatment.

Andrews[1] uses the following doses in infants:

Size of Applicator	Distance (Cm.)	Dose (Mg. hours)
Square, 2 by 2 cm. (4 sq. cm.)	1	200
Square, 4 by 4 cm. (16 sq. cm.)	1	350
Rectangle, 4 by 5 cm. (20 sq. cm.)	3	800
Rectangle, 2.5 by 1.7 cm. (4.2 sq. cm.)	1	250

The radium salt plaques should be at least half strength and preferably of full strength, (5 milligrams per square centimeter.) A glazed half strength plaque 2 by 2 centimeters screened with 2 millimeters of brass plus a rubber dam should be applied in close contact with the lesion for seven hours. Intervals of three months, and not over a maximum of six treatments should be given to the same area of skin. There should be no increase in the dose or the frequency because of lack of response.

Small lesions may be adequately irradiated with a brass tube applied at a distance of two millimeters with a two millimeter brass wall, distance being achieved by the thickness of a tongue depressor and the time of exposure for 25 milligrams being two or three hours. Such a tube may be applied (in contact) to a small angioma on the lip for from thirty minutes to one hour, while the child is asleep.

Interstitial implantation of gold radon seeds. Surface radiation is adequate in those strawberry marks where involvement is not very deep and where applications can be made satisfactorily. But most hemangiomas have elements some distance from the surface, and

the supplying arteries (around which recurrences most often start) may be deep. The latter, though in need of the most intense treatment, receive the least from surface radiation. Thus, to cure the lesion, so much surface radiation must be given as to damage the skin, and burns of the skin may occur with underlying active angiomatous tissue still present. If surface radiation is thus not suitable, we can consider interstitial implantation of gold radon seeds.

In Brown and Beyers'[2] experience this is the most valuable method where surgical excision or surface radium is not applicable. Preservation of facial features is the most important single benefit from the method. Surgical removal of growths from the eyelids, lips and nose may sacrifice so much of the features that a long series of repairs may be necessary. Or there may be such depth of involvement that sufficient surface radium application would endanger the skin. The location of the growth determines its importance in respect to size. A small lesion on the eyelid might be too large for excision, whereas very large lesions on the body or thighs can usually be excised. Sometimes the area of involvement is so located as to make surgery dangerous to an important structure. This is the case when angiomata are found on the seventh nerve or in the parotid regions. Interstitial radiation in this region has been very successful. Deep growths in this area may be entirely and permanently eradicated in a single treatment.

Interstitial therapy by means of gold implants is used for bulky angiomas. It is particularly favored for those that are deep beneath the skin or for those that involve mucous membranes of the lips, tongue and other inaccessible parts.

Interstitial radiation can damage the overlying skin and it is best to keep the seeds well under the skin if possible. Since this cannot be done in the finer features (such as the eyelids and nostrils) the dose should be carefully guarded, and seed of very small content used. Small dosage is used close to the nasal cartilages and bones.

If non-removable gold seed is used, no real trouble need be expected; occasionally one works to the surface and is discharged or has to be removed. On the scalp or about the face, if they make unsightly lumps close to the surface they can be removed.

Method of Interstitial Implantation: The implant, which contains radon, is a tiny gold tube about four millimeters long and 0.6 millimeters in diameter with a wall thickness of 0.2 millimeters. This filtration absorbs most of the beta rays, so, that, practically only gamma radiation is emitted. For angiomas the implant should contain 0.25 to 1 millicurie. This implant is used for each cubic centimeter of angioma. In treating lesions about the eyelids, nose, lips and ears, seeds of 0.25 millicuries should be used. For large and growing tumors 0.5 millicuries are available. Occasionally 1.0 millicuries may be needed if the lesion is very large and deep. By a puncture wound through the normal tissue at the edge of the angioma, insert the implant into the center of the nevus and leave it there. It is important to insert the implant deep enough to avoid atrophy of the overlying skin. It should lie with its long axis parallel to the surface but at a depth of at least a half centimeter from the surface.

After such treatment the angioma becomes swollen especially during the second and the third week. After this time the swelling subsides completely. It requires several months for the full benefits to appear.

In the treatment of 128 cases of hemangioma by radium, Andrews[1] obtained a perfect result with no atrophy, and no scarring in 95 cases. In the other 33, the results although not perfect were satisfactory.

TREATMENT OF THE LYMPHANGIOMAS

Hygromas should be removed surgically. Lymphangioma simplex, lymphangioma cavernous and hemolymphangiomas are treated with the same modalities as are the hemangiomas. Surgery, electro-coagulation, solid carbon dioxide, and radiation therapy (both roentgen and radium) have been used. Good results have been obtained when the proper modality has been used for individual cases. The mixed hemangiomas and lymphangiomas respond as well to radiation as either alone.

316 Broadway

A list of 20 references appears in the author's reprints.

PROSTATIC-HEMORRHOIDAL IMPOTENCE SYNDROME

Harold B. Schwartz, M.D., Union City, N. J.

Purpose of this paper is to emphasize an apparent relationship between sexual impotence, prostatic enlargement, and rectal conditions. In this series of only 50 cases, a definite conclusion cannot be reached but a number of striking similarities presented themselves which suggested the presence of some anatomico-pathologic situation and a probable explanation is herewith offered.

Most of the cases were seen during military service. This tended to alert one to the higher ratio which probably existed in civil practice, and which went unrecognized for the want of complete examination and correct inference of sexual history.

Four typical cases are presented—two from the military, and two from civilian practice. One was referred for perineal pain and constipation. The impotence was brought out in routine questioning. The second case of "bleeding piles" was recorded due to the interest on the part of the proctologist who was cognizant of the urologic relationship and the writer's attempt to correlate impotence symptoms. The third patient presented a partial rectal prolapse and offered the question of impotence voluntarily. The fourth case was that of internal hemorrhoids treated by injection, with impotence the primary complaint.

CASE 1

A sergeant in the Regular Army, age 39, presented himself at the G. U. clinic with complaint of pain "in back of his testicles" and constipation of long duration. He had had gonorrhea in 1938, which had been treated with sulfanilamide. He was divorced in 1944 after three years of married life with no sexual incompatibility.

For the past eight months, patient has been aware of a fullness in his perineum. This condition has been intermittent and on a few occasions almost painful. Bowel movements are irregular, patient only going when the desire for bowel evacuation is present. Following a hard stool passage, the feeling of fullness would disappear; he also noted with straining at stool some mucoid urethral discharge. No dysuria was present although some increased frequency has been noticed lately. Nocturia varies; once or twice a night. There was some delay in initiation of micturition, but force and flow are unimpaired.

Questioning about potency revealed poor erections and decline of sexual desire since onset of perineal condition.

Proctologic report gave complete clearance for any rectal condition. Digital rectal examination showed prostate to be enlarged and boggy throughout; it was slightly tender. Pressure produced copious amount of prostatic fluid. Microscopic examination of wet smear showed no abnormal amount of pus cells. Posterior urethroscopy revealed no scarring of deep urethra or verumontanum.

Following prostatic massage, patient felt relieved of perineal distress. Therapy consisted of weekly massage and caution as to bowel regularity. After six weeks, he volunteered the information of general well-being, better erections, improvement in libido, and even the intention of remarrying. Rectal examination at this examination and two months later are recorded as: prostate small, firm, not tender. Bowel movements regular.

CASE 2

A 27-year-old soldier, presented himself with complaint of constipation, rectal bleeding and pain on straining at stool. The latter had been present for six months. Genito-urinary history negative, except for a definite increase in urination and nocturia.

Routine questioning regarding sexual proclivity revealed a loss of sexual desire and inability to maintain an erection.

Rectal examination disclosed a complete ring of external hemorrhoids, of moderate size. Prostate was moderately enlarged, soft throughout, slightly tender. A hemorrhoidectomy was done with an uneventful postoperative course. Urinary urgency was absent and his sexual prowess, as he put it "was back to where it should have been in the first place". Rectal examination showed prostate to be smaller than on original examination, more firm and less tender. After six months, he was still potent and the rectal symptoms were negative.

CASE 3

A painter 38 years of age, had a history of intermittent rectal bleeding and mucoid discharge. He reported constipation and straining at stool with feeling of rounded fullness in the rectum. This condition had been present for two years. There was no rectal pain. Bowel movements cause urinary difficulty of poor stream and intermittency, although on standing to urinate, patient has no obstructive symptoms. He reported inadequate sexual powers and reduced libido. This has been present since onset of rectal trouble and patient feels there is some connection between the sexual and rectal difficulties.

Physical examination was negative, except for rectal findings. A few external tabs were present. On straining, a partial prolapse of rectal mucosa to anal orifice was visible. Proctoscopy showed minimal mucosal changes. The prostate was boggy,

enlarged and tender. Prostatic smear showed normal constituents. Rectal surgery was done but no other therapy was given and four months later, patient offered no rectal complaints. Urinary difficulty with bowel movements disappeared and sexual power returned with impetus.

CASE 4

An aeronautical mechanic, age 57, was seen complaining of impotence of six months duration. Further questioning revealed some mild difficulty in urination, slight delay in initiation of micturition, nocturia 3 times, and diuria seven times. Constipation has been present all his life, and on a number of occasions, bright red blood was noted with stool movements.

Rectal investigation disclosed a complete ring of internal hemorrhoids, varying size, not pedunculated or prolapsed on straining. He had a soft, slightly tender, moderately enlarged prostate. Prostatic smear showed no abnormal findings. Panendoscopy showed posterior urethra to be moderately elongated without intravesical or marked intraurethral prostatic intrusion. Lateral lobes were non-kissing with round vesical neck.

Patient was treated by proctologist with weekly injections of quinine and urea hydrocloride into each rectal quadrant. Two quadrants were treated each week for eight weeks.

Rectal bleeding ceased immediately and the injection result was considered excellent. During the course of treatment, his urinary symptoms were greatly improved. Prostate was diminished in size, smooth, firm, not boggy. Quality of erections definitely improved. Recheck at the end of six months disclosed patient to have maintained his virile state. No rectal bleeding was noted. Prostate remained unchanged in configuration as compared to previous examination.

COMMENT

Impotence in the above cases are considered partial or secondary to some organic disturbance. However, primary impotence with psychic background must not be confused with organic states. Prostatic and rectal clearance should be obtained in every case. Herman's classification * of organic pathology that may predispose toward partial or total impotence with superimposed psychic factors must be excluded. His classification is as follows:

A. Penile Dysfunction of Mechanical Origin:
   1. Congenital Abnormalities.
      (a) Absence of penis, hermaphroditism.
      (b) Extreme smallness of penis.
      (c) Extreme largeness of penis.
      (d) Defective development of the cavernous bodies, leading to flabby and incomplete erections.
      (e) Penile curvature incident to hypo- or epispadias.
      (f) Various defects of the prepuce, frenum, etc.
   2. Acquired Abnormalities.
      (a) Defects of the cavernous tissue such as penitis, indurative cavernositis, cavernositis following stricture and leading to curvatures of the penis, flail penis, etc. Fracture of the penis and priapism may have similar end-results.
      (b) Loss of the penis from surgical, accidental or criminal amputation, or as the result of self-mutilation.
      (c) Ulcerative destruction of the penis—tuberculosis, syphilis, chancroid, pyogenic penitis, granuloma inguinale.
      (d) Penile dysfunction resulting from large herniae, hydrocele, elephantiasis, etc.
      (e) Urethral fistulae (acquired or congenital).

B. Impotence of Endocrine Origin:
   1. Congenital.
      (a) Malformation of the testicles—monorchism, cryptorchism, and hypoplasia.
      (b) Malformation of the thyroid gland—cretenism, hypoplasia.
      (c) Malformation of the hypophysis cerebri —Frohlich's syndrome.
   2. Castration.
      (a) Castration.
      (b) Destructive disease of the testicles.
      (c) Acquired hypothyroidism (myxedema).
      (d) Obesity.

C. Impotence Secondary to Diseases of the Internal Genitalia.

D. Impotence Due to Diseases of the Nervous System—Brain, Cord, or Peripheral Nerves.

E. Impotence Due to Various Acute and Chronic Diseases and Intoxications:
   Bacterial toxemia.
   Auto-intoxications.
   Chemical intoxications (alcohol, tobacco, drugs).
   Anemia, etc.

No definite conclusion can be drawn from a small series of fifty cases, but a relationship may be inferred as existing between prostatic enlargement, rectal conditions and sexual impotence. Sexual stamina and feeling of well-being on follow-up examination emphasizes the genito-rectal relationship.

ANATOMY

On the basis of an anatomic and physiologic relationship the blood supply of the prostate and rectum is closely allied. The congestion and swelling present in venous stasis hold true in rectal varices. The *venae comites* of the internal pudendal artery begin with tributaries

* Herman, L.: *The Practice of Urology*. Saunders, Philadelphia, 1936.

which emerge from the pudendal plexus, which lies below and posterior to the arcuate ligament of the pubis and constitute the anterior part of the prostatic plexus. They receive blood from the corpus cavernosum by the deep vein of the penis. They follow the course of the internal pudendal artery and usually join together into a single vessel, the internal pudendal vein which terminates in the hypogastric vein. They receive as tributaries the veins from the bulb, perineum, and inferior hemorrhoidal veins.

The inferior hemorrhoidal veins begin in the substance of the external sphincter of the anus and in the walls of the anal canal, anastamose with the superior and middle hemorrhoidal veins.

The lymphatic association of the prostate and the rectal wall correlating its vascular anastamosis is obvious.

BASIS FOR THERAPY

It is reasonable to accept the presence of a passive vascular and lymphatic congestion of the prostate, on the basis of venous stasis of the hemorrhoidal veins. Therefore, with removal of the varicose rectal veins, a relief of the prostatic congestion should result. The sexual improvement in the four patients presented with subsidence of the prostatic swelling after therapy, attest to the probable presence of a prostatic, hemorrhoidal and impotence relationship.

A definite conclusion is not being offered, but the relationship has undoubtedly been observed by others. Evaluation after a sufficient number of cases can be followed up and analyzed will further aid in materializing this syndrome.

3906 Bergenline Avenue

PENICILLIN AND STREPTOCOCCIC THROAT

Doctors are forever seeking an ideal therapy for the effective and rapid cure of sore throat. One contribution towards this quest is penicillin. In a recent issue of the *J. A. M. A.*, Selvan Davison reports that most victims of streptococcic sore throat exhibited complete recovery within three days. The author cites one investigator who previously had treated 28 cases of acute sore throat with penicillin, using 15,000 units every four hours, day and night. In this study, it was found that cases treated for less than six days with 15,000 unit dosages of penicillin showed comparatively poor results because of frequent relapses; yet patients treated for six full days showed excellent results.

Davison says that on the basis of the previous investigation, he studied the possibility of giving a shorter but more intensive course of penicillin treatment.

All of Davison's patients were young adults with no complicating diseases. No patients were treated who had been ill for more than 48 hours.

Penicillin was administered in the amount of 20,000 units every three hours, day and night, by intramuscular injection. The average total dosage of penicillin was 360,000 units over a period of 54 hours.

There was only one relapse, in which recovery occurred without further penicillin. One did not respond until sulfadiazine replaced penicillin as the treatment.

Most patients showed complete recovery in two or three days. The patients from whom no bacteria were obtained displayed normal throats in an average of under four days.

"It must be remembered," Davison writes, "that the periods of time noted are the upper limits. Disappearance of symptoms and of signs means complete absence. There had to be not the slightest pain on swallowing nor any remaining exudate or inflammation before a time element was established."

MARKED TOXIC SIDE EFFECT OF PYRIBENZAMINE

E. CLARENCE KERN, M.D., Montclair, N. J.

The effectiveness of the anti-histamine drugs in allergic disease has resulted in their widespread use. All of these drugs so far available have undesirable side effects. These side effects have been, in the order of their frequency: (1) sedation, (2) excitation, (3) slight dizziness, (4) chilly sensation, (5) gastric irritation. For the most part, these symptoms have been mild, and the patient has been forewarned in time so that the medication could be stopped before more pronounced symptoms developed. However this is not always true as will be seen from the case reported.

Mrs. E. W., aged 28, was given a histamine test subcutaneously for allergic status. This test showed a three-plus reaction on a scale where four-plus is maximum and thus indicated probable allergy. Pyribenzamine hydrochloride was prescribed and the patient was told to take one tablet three times a day. (The suggested dosage often runs as high as six tablets a day.)

She took her first dose after dinner that night. Subsequently she fainted and remained unconscious for several minutes. Next morning, after breakfast, she took a second tablet. While taking a bath soon after she became so weak that she was unable to get out of the tub without assistance. Instead of discontinuing treatment she took a third tablet after lunch. She became weak, went to bed and fainted again. A local doctor was called who advised the patient to cease taking the pyribenzamine. He prescribed strychnine. The patient was prostrated all afternoon and evening but recovered the next day. According to her mother she was under treatment at the time for low blood pressure and subnormal temperature.

Conclusion: Anti-histamine drugs should be used with great care. The first doses should be considerably smaller than those now advocated for treatment.

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ASSOCIATES

Hall, Mary B., 4 W. Chestnut st., Bordentown (11)
Kandle, Roscoe, 20 Edgemere av., Trenton (11)
McCormack, Raymond A.,873 Bellevue av.,Tr't'n(11)

STATE ACTIVITIES

PLACES ON ANNUAL MEETING PROGRAM STILL OPEN

If you have an exhibit to display, a paper to read, or an idea to promote at the Annual Meeting of The Medical Society of New Jersey in April, 1948, this is the time to tell the Committee. Entries will close at the end of September, so promptly notify the Annual Meeting Committee, The Medical Society of New Jersey, 315 W. State Street, Trenton 8, N. J.

In addition to the existing sections, seven new ones have been formed and will join scientific meetings in 1948. These are: (1) Anesthesiology, (2) Orthopedics, (3) Clinical Pathology, (4) Metabolism, (5) Neuropsychiatry, (6) Chest Diseases and (7) Venereal Disease Control.

THE NEW JERSEY DIABETES ASSOCIATION

The New Jersey Diabetes Association, Inc., received official affiliate status from the American Diabetes Association on June 6, 1947.

Objects of this association are:

1. To disseminate information among physicians relative to the diagnosis and treatment of diabetes by means of meetings, bulletins and scientific publications.
2. To educate the laity in the early recognition of diabetes and in the realization of the importance of medical supervision.
3. To make and publish statistical surveys in diabetes.
4. To cooperate with other related associations, such as those concerned with child welfare, nutrition, tuberculosis, eye diseases, etc.
5. To establish a summer camp for indigent and other diabetic children.
6. To help establish accredited diabetic clinics in hospitals throughout the state with their certification upon fulfillment of proposed established requirements.

The Board of Governors includes recognized specialists in diabetes who have metabolic services or clinics in accredited hospitals.

The Clinical Society is the scientific branch of this Association. Under its direction, three or four scientific meetings a year will be held at the Academy of Medicine in Newark.

The first meeting will be held on October 16 and the speaker will be Dr. E. P. Joslin of Boston.

Membership in the Clinical Society is available in three categories: (1) *Fellows,* who are recognized specialists in diabetes or in specialties closely associated, such as surgery and ophthalmology; (2) *Associates,* who are interested in diabetes but are not necessarily specialists: (3) *Regular members,* who will be nurses, technicians, dieticians, etc.

Communications to the society should be addressed to The New Jersey Diabetes Association, 91 Lincoln Park, Newark, New Jersey.

Applications for membership should be forwarded to Dr. S. Weiss, chairman of the Admission Committee at the same address.

Benjamin I. Saslow, M.D.,
President, N. J. Diabetes
Association.

CHEST PHYSICIANS PROGRAM

Announcement is made of a scientific meeting of the New Jersey chapter of the American College of Chest Physicians, to be held at the Valley View Sanatorium, Paterson, N. J., on October 21, 1947. The program begins promptly at 9 p. m., and includes presentation of three interesting chest cases, and a talk on *Recent Advances in the Treatment of Common Chest Conditions.* Essayist of the evening will be Dr. Benjamin Potter. All physicians are welcome.

FALL CLINICAL CONFERENCE
PATERSON AND PASSAIC, NEW JERSEY

OCTOBER 29, 1947

Morning Sessions 10 to 12 A. M.

ST. MARY'S HOSPITAL, PASSAIC

1. "Errors in Surgery and Medical Diagnosis in the Treatment of Fibromyositis" by Edward P. Whelan, M.D.
2. "The Acute Gall-bladder" by B. P. Willis, M.D.
3. "Management of Compound Fractures" by Roy R. Ciccone, M.D.
4. "A Plea for Conservative Treatment of Facial Injuries" by D. McCallaugh Mayer, D.D.S., M.D.

PASSAIC GENERAL HOSPITAL

1. "Practical Demonstration and Indications for Shock Therapy in Psychiatric Patients" by David J. Flicker, M.D., and J. Lloyd Morrow, M.D.
2. "Treatment and Prevention of Thrombophlebitis and Phlebothrombosis" by Morris Joseph, M.D.
3. "Rh Factor in Clinical Application" by William M. Sullivan, M.D.
4. "Comparative Values of the Anti-acids" by Irving Ehrenfeld, M.D.

BETH ISRAEL HOSPITAL, PASSAIC

1. "Nutritional Factors in Production of Cirrhosis of the Liver" by M. Wachstein, M.D. (Original experimentation study.)
2. "Anti-coagulants" by J. Freedman, M.D.
3. "Regional Ileitis" by E. Schlossberg, M.D.
4. "Recent Advances in the Treatment of Edema" by J. Reuben Budd, M.D.

VALLEY VIEW SANATORIUM, PATERSON

1. Inspection of the Sanatorium — 9:00 to 10:00 a. m.
2. "The Clinical Significance and Management of Minimal and Early Pulmonary Tuberculosis" by David Reisner, M.D.
   Discussion by William Weintraub, M.D.
3. "Cytology of Bronchial Secretions in Pulmonary Carcinoma and Tuberculosis" by Peter A. Herbut, M.D.
   Discussion by Theodore Martin, M.D.
4. "Tuberculosis Case Finding Surveys" by A. Joseph Hughes, M.D.
   Discussion by Kent Salter, M.D.
5. Collation—12:30.

PATERSON BOARD OF HEALTH

1. "The Public Health Laboratory in Relation to Community Health with Special Reference to the Rh Factor Tests." Conducted by Frederic P. Lee, M.D.; Miss Anna I. Van Saun, director Division of Laboratories, and Miss Evelyn L. Brown, assistant director.
   (a) Practical Demonstration of the Rh Determination.
   (b) Demonstration in blocking bodies and their significance in pregnancy.
   (c) Value of exsanguination as a therapeutic.
2. "Exsanguination-transfusion for Erythroblastosis Fetalis" by S. Gelman, M.D., and M. A. Shinefeld, M.D.

BARNERT MEMORIAL HOSPITAL, PATERSON

1. "Present Day Concept of Treatment of Syphilis" (with lantern slide demonstration) by Samuel Fisher, M.D.
2. "Celiac Disease" by S. A. Levinsohn, M.D.
3. "Caudal and Saddle Block Anesthesia in Obstetrics" by A. Shulman, M.D., and I. R. Hayman, M.D.
4. "Disseminated Lupus Erythematosus" by Louis G. Shapiro, M.D.

ST. JOSEPH'S HOSPITAL, PATERSON

1. "The Clinical Aspects of Hepatitis" by Francis Meyers, M.D.
2. "Laboratory Findings in Hepatitis" by F. M. Offenkrantz, M.D.

3. "Differentiation of Some Surgical Conditions that Simulate Hepatitis" by Andrew F. McBride, M.D.
4. "Pathology of Hepatitis" by Gay B. Kim, M.D.
5. Discussion by C. Gormley, M.D.
6. "The Rh Factor" by Theodore K. Graham, M.D.
7. "Erythroblastosis" by J. Morrill, M.D.
8. Discussion by Joseph Jehl, M.D.

PATERSON GENERAL HOSPITAL

1. "Hepatic Cirrhosis" by A. G. Markel, M.D.
2. "Delay in the Diagnosis of Cancer" by John E. Leach, M.D.
3. "Management of Arteriosclerotic Heart Disease" by Arthur De Graaf, M.D.
4. "Diagnosis and Treatment of Tumors of the Lung" by Raymond E. Banta, M.D.

INDUSTRIAL MEDICINE CLINICS

1. Manhattan Rubber Manufacturing Division of Raybestos-Manhattan, Passaic.
   (a) "Infections and Injuries of the Hand" by Joseph M. Keating, M.D.
   (b) "Demonstration of Safety Devices and Methods in the Mills."
2. Botany Mills, Passaic.
   (a) "Setting Up an Industrial Clinic" by Mrs. Monttel, ex-President, Industrial Nurses' Association.
      1. Procedures
      2. Employees' examinations
      3. Processing of workers
      4. Coordinating industrial work with private practice.
   (b) Luncheon
3. Hoffmann-La Roche, Nutley.
   (a) Brief explanations of functions of a pharmaceutical plant.
   (b) Tour — showing pharmacology, fundamental research work, ampule filling, tablet making, bulk organic chemical production.
   (c) Production of ascorbic acid.
   (d) Luncheon.
4. Wright Aeronautical.
   (a) "Industrial Backs" by Robert Brendan O'Connor, M.D.

ROUND-TABLE LUNCHEON

1:00 to 2:30 p. m.

at the Alexander Hamilton Hotel, Paterson

"A System for the Treatment of Congestive Failure"

by

Harry Gold, M.D.

AFTERNOON SESSION

at the Alexander Hamilton Hotel, Paterson

3:00 to 4:00 p. m.—"Recent Advances in Sulfonamide Treatment and the Prevention of Renal Complications" by David Lehr, M.D.

3:30 to 4:00 p. m. — "Recent Advances in Treatment With Penicillin and Streptomycin" by Ralph R. Tompsett, M.D.

4:00 to 4:30 p. m.—"Recent Advances in Cancer Research" by David A. Karnofsky, M.D.

4:30 to 5:00 p. m.—"Recent Advances in Surgery of the Gastro-Intestinal Tract" by Henry W. Cave, M.D.

DINNER

6:00 to 7:00 p. m.—Cocktails at the Alexander Hamilton Hotel, Paterson.

7:00 p. m.—Dinner.

EVENING SESSION

(Following the Dinner at the Alexander Hamilton Hotel)

"The Elias J. Marsh Oration"

"The Continuing Education of Physicians; A Forecast of Imminent Changes"

by

George Baehr, M.D.

Central registration desk at Alexander Hamilton Hotel, 55 Church Street, Paterson. Physicians who attend any of these sessions, are requested to register at that desk some time during the day.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

ORGANIZED BY

THE MEDICAL SOCIETY OF NEW JERSEY

As of July 31, (1947) 124,029 persons were enrolled under effective contracts, an increase of 8,459 persons during July.

WAITING PERIOD IN OBSTETRICAL CASES

Effective with respect to hospital admissions occurring on and after September 1, 1947, the waiting period for maternity services is reduced from nine to eight months. Obstetrical care, in eligible cases under Family Subscription Contracts may receive benefits as pertain to pregnancies which terminate at full term not less than eight months after the effective date of the Subscription Contract, or for eligible services rendered incident to pregnancies in which full term birth is anticipated not less than eight months after such effective date.

rate of the Plan is based upon a study of services rendered to persons admitted to hospitals for treatment.

The Plan has found by experience that benefits can be made available in the following situations which would have been eligible if treated in a hospital, but for which admission to a hospital for bed occupancy did not occur:

1. Tonsillectomy, if otherwise eligible under the Subscription Contract, when performed in the office of a fully licensed physician.
2. Maternity services, if otherwise eligible under the Subscription Contract, when rendered outside of hospital at time of *full term birth.*
3. Emergency surgical services when rendered in the out-patient department of an approved hospital without admission for bed occupancy.
4. Emergency surgical services occasioned by accidental injury and rendered by an eligible physician, for an eligible condition under the Subscription Contract, anywhere within 24 hours after the accident, (toward, but not in excess of the physician's charges to the patient for such services) in accordance with the Plan's Schedule of Benefits, but not exceeding $25.00 in connection with any one accident.

The Plan aims at all times to operate within the framework of our present methods of practice, and according to the expressed policies, traditions and ethics of the profession.

Consistent with this the Board of Trustees of the Plan believes that the patient is entitled to know the cost of a physician's service at the time the service is requested.

The Board suggests that when a patient, not entitled to full service benefits in accordance with the schedule of benefits of the Plan, requests the services of a Participating Physician, that the patient and physician agree at this time on the amount of any additional payment to be made.

BENEFITS FOR ANESTHESIA

The benefit for general, spinal and intravenous anesthesia administered by a private physician, has been increased from $10.00 to $12.50 except for general anesthesias or intravenous anesthesia administered for tonsillectomies and vaginal deliveries, which will remain at $10.00. The benefit for eligible intratracheal anesthesia and for caudal obstetrical anesthesia remains at $25.00.

ELIGIBLE SERVICES

Occasionally the Plan receives bills for services not eligible for benefit under its subscription contract. This is usually due to misunderstanding of the contract provisions. The Plan provides benefits for eligible services rendered by fully licensed physicians to eligible persons admitted to approved hospitals for bed occupancy treatment. The subscription

The Plan, as a non-profit organization, is designed to be as fair and liberal as possible in the scope of eligible services and in the amount of benefit paid in accordance with the Subscription Contract and the Plan's Schedule of Benefits, based on sound financial practice and in the interest of all of its Subscribers.

SCHEDULE OF BENEFITS

The Schedule of Benefits (amounts payable to physicians) is designed to be consistent with a subscription rate and within the ability

of subscribers, of below average income, to pay.

The Schedule of Benefits does, we believe, represent fair fees for services rendered the low income group for which the benefit constitutes payment in full. For this group it provides a means of complete payment for eligible services within their ability to pay, in order to evolve a solution for the medical care distribution problem.

EXPERIENCE, JANUARY 1, 1947—JULY 31, 1947

Earned Income	$496,923.70
Claims Accrued	375,394.65
Administrative Cost	85,261.08
Earned Reserve	36,268.05

NON-PARTICIPATING PHYSICIANS

The Plan has enrolled groups in every county in New Jersey. There are probably some physicians, particularly those recently returned from military service, with whom the Plan is not under contract. Of the 4500 private practitioners in the state, 3,700 are Participating Physicians of the Plan. Further information regarding the Plan, and copies of the Plan's "Agreement with Participating Physicians" may be obtained by writing to the Executive Office of the Society in Trenton or to the office of the Plan at 31 Clinton Street, Newark 2. Telephone MItchell 2-0675.

NORMAN M. SCOTT, M.D.,
Medical Director.

OBITUARIES

DR. WALTER E. D'ARCY

The citizens of Trenton lost one of their distinguished civic leaders, and the profession lost a valuable and active colleague on July 24, when Dr. Walter E. D'Arcy died on that day. President of the Board of Education and medical director of the McKinley Hospital, Dr. D'Arcy had long been associated with hospital, medical society, educational and communal activities in the Mercer County area. He was graduated from the Hahnemann Medical College of Philadelphia in 1909, and came to Trenton shortly thereafter. He was appointed to the staff of the McKinley Hospital in 1910 and remained closely identified with that institution for the rest of his professional career. Rapidly advancing through the various clinical ranks, he became medical director of the hospital in 1936, and remained in that position until his death. He was a Fellow of the American College of Surgeons. His labors on behalf of organized medicine won for him the presidency of the Mercer County Medical Society. He was appointed to the Trenton Board of Education in 1943, and two years later was reappointed and then elected president of that Board. His only daughter, Mrs. William Treptow, was long associated with the office staff of The Medical Society of New Jersey.

DR. RUSSELL A. SHIRREFS

Dr. Russell A. Shirrefs, honorary member of the Union County Medical Society, and one of the senior practitioners of Elizabeth died at his home in that city on July 15. Born in Bridgeton, N. J., he came to Elizabeth in childhood. He was graduated from the College of Physicians and Surgeons in 1899 and shortly thereafter began a private practice that was to become one of the largest in Elizabeth. He became coroner of Union County in 1902, and was for many decades active on the attending staffs of the three hospitals in Elizabeth. He was a leader in Masonic circles, and was elevated to the highest degree in that craft in 1927. He was especially well known for his interest in floriculture and horticulture, and his flower garden on Elmora Avenue has long been a landmark in Elizabeth. In 1944, his colleagues symbolized his devoted and efficient service to the public and profession by unanimously electing him to honorary membership in the Union County Medical Society.

The day after his death, the county society called a special memorial meeting at which a resolution of condolence and regret was adopted. His passing was characterized in the resolution as "ending the career of a brilliant and gentlemanly scholar".

COURSE IN ALLERGY

The University of Cincinnati in cooperation with the American College of Allergists announces a graduate course in allergy to be given in Cincinnati November 3-8 inclusive. Programs and further details may be obtained by writing to Dr. Fred W. Wittich, 423 La Salle Medical Building, Minneapolis 2, Minnesota.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

October 5 to 11 has been proclaimed by The Medical Society of New Jersey as *Public Health Week*. It will be the occasion for many significant public health meetings in the state.

The American Public Health Association returns to New Jersey for the first time since 1941, when the 75th Annual Meeting of this National Association will be held in Atlantic City, October 6 to 10.

New Jersey Day will be Wednesday, October 8, and will be marked by the 73d Annual Meeting of the New Jersey Health and Sanitary Association at the Hotel Ambassador. Surgeon-General Thomas Parran will be the speaker of the evening upon the joint invitation of the New Jersey Health and Sanitary Association, the New Jersey Health Officers Association and the State Department of Health. His topic will be *Progress Towards a National Health Program.* Reservations for this dinner meeting may be made by writing to John Hall, Box 1, Freehold, N. J., or may be secured at the registration desk of the American Public Health Association.

Meetings of the American Public Health Association will include sections on epidemiology, maternal and child health, public health nursing, school health, industrial hygiene, laboratory and health education and will be held throughout the week. For the detailed program, write to the American Public Health Association, 1790 Broadway, New York 19, N. Y.

STATE PUBLIC HEALTH COUNCIL ELECTS

At the organization meeting of the new State Public Health Council on August 11, Wheeler McMillen of Hopewell was elected chairman, Dr. Marcus W. Newcomb of Brown's Mills, vice-chairman, and Mrs. Florence M. Farr of Brookside, secretary. The Public Health Council replaces the old State Board of Health under Chapter 177, P.L. 1947, and will meet the second Monday of each month.

SOME SMALL WATER SUPPLIES NO LONGER "PUBLIC"

It has been the policy of the State Department of Health since 1932 to consider all water supplies serving eight or more properties as public water supplies; and, therefore, the Department has supervised such supplies requiring engineering data for approval of the supplies and additions and alterations to them, licensed operators, and quarterly submission of samples for analyses by the Department.

The new licensing act, defines a public water supply system as "a system comprising structures which operating alone or with other structures result in the derivation, conveyance or distribution of water for potable or domestic purposes to consumers in twenty or more dwellings or properties; this definition does not include a public water treatment plant."

The effect of the new law is to change, from eight to twenty, the number of properties served by the smallest *public* water supply. Supervision as to safeness has, therefore, been discontinued by the State Department of Health. Routine inspections by sanitary engineers of the Department have also been discontinued in cases of water supplies serving less than twenty premises.

This does not disturb the authority of local boards of health, nor does it affect the quality of water used at public places.

BEFORE YOU MAIL THAT SPECIMEN

The Bureau of Bacteriology received complaints recently from postoffice officials concerning specimen mailing containers broken in transit. Serology specimens are the chief cause of complaint.

When a specimen is improperly packaged, it damages other first class mail and smears the information slip making it unidentifiable. The specimen may be lost, so that the doctor fails to receive a report on the specimen.

Serology mailing containers are prepared according to the Postal Laws and Regulations, Section 589, and specimens should arrive at the laboratory in good condition in these containers.

Doctors, nurses and health officials mailing specimens are requested:

1. To see that the blood vial is securely stoppered.
2. To replace the absorbent packing supplied in the mailing tube.
3. To screw the metal cap container cover securely.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY MEETING DATES
1947—1948

County	1947 Sept.	Oct.	Nov.	Dec.	1948 Jan.	Feb.	Mar.	Apr.	May	June
Atlantic (Fri.)	12	10	14	12	9	13	12	9	14*	..
Bergen (Tues.)	9	14	11	9	13	10	9	13	11*	8
Burlington (Thurs.)	11	9	13	11	8	12	11	8	13*	..
Camden (Tues.)	..	7	4	2	6	3	2	6	4*	..
Cape May (Tues.)	..	28	25	23	27	24	23	20	25*	..
Cumberland (Tues.)	..	14	..	9	..	10	..	13*	..	8
Essex (Thurs.)	..	9	13	11	8	12	11	8	13*	..
Gloucester (Thurs.)	18	16	20	18	15	19	18	15	20*	..
Hudson (Tues.)	..	7	4	2	6	3	2	6	4*	..
Hunterdon (Tues.)	..	28	..	..	27	..	..	27*	..	..
Mercer (Wed.)	..	8	12	10*	14	11	10	14	12	9
Middlesex (Wed.)	..	15	19	17*	21	18	17	21	19	16
Monmouth (Wed.)	24	22	26	17	28	25	24	21*	26	23
Morris (Thurs.)	..	16	..	18	..	..	18	..	..	17*
Ocean (Wed.)	10	8	12	10	14	11	10	14	12*	9
Passaic (Tues.)	16	21	18	16	20	17	16	20	18*	..
Salem (Fri.)	19	17	21	19	16	20	19	16*	21	..
Somerset (Thurs.)	..	9	13	11	8	12	11	8	13	10*
Sussex	Sept., Dec., Feb., May—time and place designated by President									
Union (Wed.)	10	..	12	..	14	..	10	14*	12	..
Warren (Tues.)	..	21*	..	..	20	..	..	20	..	..

* Annual Meeting

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The annual meeting of the *Bergen County Medical Society,* held at Bergen Pines Hospital, Oradell, on the evening of May 13, was called to order by the president, DR. ALBERT W. CLOUD, at 9:12 p. m.

The minutes of the regular meeting of April 8 were accepted as read by the secretary. The minutes of the Executive Committee meeting of April 15, were approved as published in the Bulletin.

DR. WALTER J. FARR, Chairman of the Entertainment Committee, reported that the Annual Field Day will be held at Bergen Pines Hospital on the afternoon and evening of June 19. Following a program of athletic events and entertainment, the newly elected officers will be installed.

Dr. Robert H. Ringewald moved that the individual members of the Bergen County Medical Society be circularized to obtain views in regard to the Bergen County Hospital Plan, and that the Society go on public record after the members' opinions have been obtained.

On recommendation of the membership committee, the following applicants were elected to full membership: Dr. Eugene A. Andrick, Hohokus, K. M. Delafrange, Westwood, Daniel L. Goldstein, Hackensack; Harry Rhodes, Jr., Hasbrouck Heights; Mandel Silverman, Rutherford. Drs. Thomas S. McKinney, Ridgefield Park, and Simeon Siegel, Dumont, were elected to associate membership; Drs. Frank J. Liddy, Mahwah, and D. McCullagh Hayer, Rutherford to courtesy membership.

The secretary reported that at the regular meeting of April 8, and the Executive Committee meeting of April 15, the following were presented by the Nominating Committee for office in 1947: President, DR. RUDOLPH C. SCHRETZMANN; Vice-President, DR. LUKE A. MULLIGAN; Secretary, DR. EDWARD V. SEXTON; Treasurer, DR. FREDERICK L. MULLER, and Reporter, DR. HERBERT E. REINHOLD.

Dr. George Heller introduced DR. BENJAMIN P. POTTER, Chief of the First Division, Medical Center, Jersey City, who spoke on *Recent Advances in the Management of Conditions of the Chest Commonly Encountered in the Practice of Medicine and Surgery.* His paper was most comprehensive and covered all of the more common chest conditions. He illustrated the discussion of each individual condition by numerous x-ray reproductions. His opinion that atypical pneumonia can be most confusing to diagnose was of particular interest. He pointed out that it is very difficult to differentiate a virus from a bacterial type. Therefore, he recommended the use of antibiotics in all such cases for a period of seventy-two hours. Following this, if there is no improvement, he adds sulfadiazine to the regime and if after forty-eight hours more, there is no further improvement, he stops antibiotics because of the probability that the condition is of virus

origin. In his opinion, regarding lung abscess, the patient should have four weeks of medical or bronchoscopic treatment, and if there is no improvement after that, he advises serious consideration of surgical intervention. He closed his discussion with a very interesting resume of original observations in the treatment of tuberculosis with streptomycin.

The meeting adjourned at 11:15 p. m.

The Annual Field Day and Installation of Officers of the *Bergen County Medical Society,* held at Bergen Pines Hospital, Oradell, on the afternoon of June 19, was called to order by the President, Dr. Albert W. Cloud, at 5:15 p. m.

The minutes of the regular meeting of May 13, were dispensed with until the September meeting.

At this meeting, President Cloud turned over the gavel to the newly elected president, Dr. Rudolph C. Schretzmann. "It has been a pleasure to have served as the Society's President for the past year", said Dr. Cloud, "and I appreciate the splendid cooperation received during this term of office, and hope that Dr. Schretzmann will enjoy his duties as the newly elected President". The gavel was then presented to Dr. Schretzmann by Dr. Cloud.

The newly elected President then presented Dr. George M. Levitas, Vice-President of the Board of Managers of Bergen Pines, who said that Dr. Little had been unable to attend the meeting, but wished to extend an official welcome to the officers and members of the Bergen County Medical Society. He also said that the Board of Managers hope that the Society will make Bergen Pines its official playground for meetings such as the one being held today, and that the Board is anxious that the Society members feel at home at Bergen Pines at all times. He pointed out that constructive suggestions would always be welcomed.

The newly elected Vice-President, Dr. Luke A. Mullioan, along with Drs. Edward V. Sexton, Frederick L. Muller and Herbert E. Reinhold, retaining the respective offices of Secretary, Treasurer and Reporter, were then presented by Dr. Schretzmann.

The meeting was turned over to Dr. Walter J. Farr, chairman of the Entertainment Committee, who distributed the door prizes among those present, Cosmevo Surgical Supply Co. being the donors.

The meeting adjourned at 5:25 p. m.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The last meeting of the *Burlington County Medical Society* before the summer recess was held on May 8, at the Riverton Country Club. As is the custom, it was a joint meeting of the Woman's Auxiliary and the County Society and a few friends of the members.

After the reading of the minutes of the preceding meeting and a few communications, Dr. William E. Bray, the retiring president, gave his farewell address. Dr. Bray commended the Program Committee for the excellent speakers and the wide variety of subject matter which was covered in the meetings. The Veterans Liaison Committee did a yeoman's job in determining how many veterans in Burlington County were disabled and whether or not there were a sufficient number of these to warrant establishing a Veterans Clinic. This committee concluded after their study that there were not enough disabled veterans in this county to open a clinic. The retiring president praised the Constitution and By-Laws Committee for their difficult accomplishment of revising and rewriting the Constitution and By-Laws of the County Society, which is being printed in book form and will be distributed to each member when finished. Dr. Bray stated that the Post-Graduate Committee is presenting a fine course of lectures on varied topics. The Woman's Auxiliary has worked very hard on the History of the County Society from its very beginning up to and including the present membership. This history is also being put in book form and will be distributed when completed. The Auxiliary also had a Public Relations Tea to which were invited various civic organizations and their mutual problems were discussed. It was a very successful get-together. Dr. Bray announced that Dr. J. Howard Hornberger was chosen President-elect of The Medical Society of New Jersey, which is an honor for our County Society. Dr. Bray said that he was disappointed at the small attendance at the monthly meetings with such good speakers on the program. In closing, Dr. Bray expressed the hope that the policies which had been started this year would be carried on. These are (1) education of the public to a better understanding of medical problems; (2) yearly post-graduate lectures; and (3) the establishment of a more friendly attitude toward the public by the medical profession.

The retiring president then introduced the incoming president, Dr. G. E. McDonnel of Mount Holly. Dr. McDonnel said that he was honored to be the President of the Burlington County Medical Society. The policies which were started by Dr. Bray would be continued and he hoped there would be a more social spirit at the meetings in addition to the scientific atmosphere.

CUMBERLAND COUNTY

E. C. Greene, M.D., Reporter

Members of the *Cumberland County Medical Society* held their regular monthly meeting as guests of the Owen's-Illinois Glass Company at the Onized Club Room in Bridgeton on Tuesday afternoon, June 17, and were given a warm welcome by Mr. Herbert Hill, Director of Personnel.

The business meeting followed with the president, Dr. Sidney Siegel, presiding.

Dr. Pasqual Ruggerri, Vineland, was elected to membership by transfer from the Philadelphia County Medical Society.

Following the short business session, Dr. Mary Bacon gave an interesting, comprehensive report of the scientific sessions at the meeting of the State Medical Society at Atlantic City. Dr. A. B. Kump reported on the business sessions, discussing some of the political developments at the convention.

Dr. Charles Cunningham, chairman of the scientific program, introduced Dr. Harry P. Shay, Pro-

fessor of Gastro-Enterology at Temple University School of Medicine, who gave an exceptionally interesting and informative lecture on the *Diseases of the Liver.* Dr. Shay traced the development of modern concepts of hepatic therapy through the past 25 years, from the first discovery that de-pancreatized dogs were protected from liver degeneration by a factor in the external secretions of the pancreas to the recent belief that certain protein derivatives prevent fatty degeneration of the liver.

Dr. Shay discussed the diagnosis and treatment of primary liver disease, presenting several practical and convenient liver function tests for the evaluation of hepatic damage and described in detail the recent work of several groups on infectious hepatitis which was such a constant problem to the armed forces. In closing, he differentiated the homologous serum and the virus types of hepatitis.

ESSEX COUNTY

Asher Yaguda, M.D., Reporter

At a meeting of the subcommittee on public relations of the *Essex County Medical Society* which was called by the President, DR. HARROLD A. MURRAY, the plans for Health Week were formulated.

It was decided to conduct a program under the title of "Health Week" in Essex County during the week beginning October 6, 1947. The program is to include radio broadcasts every morning during the week and educational films of special interest to both adults and school children to be shown every afternoon. Each evening, an outstanding authority will speak on a popular health subject. Exhibits on some fifteen or more health topics will be set up for the edification of the lay public audience.

The Health Week Committee adopted as its slogan *Early Discovery Means Early Recovery.*

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its final regular monthly meeting of the 1946-47 official year on May 6, at the Masonic Club in Jersey City. At 9:30 p. m. the meeting was called to order by the President, DR. C. E. MCNENNEY.

The recommendation of the Subcommittee on Resolutions that the following testimonials, suitably engrossed, be presented to the families of the late DR. DAVID I. NALITT and DR. THOMAS MCG. BRENNOCK, was unanimously approved:

Whereas, We, the officers and members of Hudson County Medical Society, learn with deep regret of the death of DR. DAVID ISAAC NALITT, and

Whereas, by reason of a long and honorable career in medicine he endeared himself to the public, whom he served with loyalty and devotion, thus exemplifying the cardinal virtues of a true physician, and

Whereas, by his participation in a most unselfish manner, in all activities pertaining to the welfare of Hudson County Medical Society, he merited the honor of being elevated to the office of president-elect, which office he held at the time of his demise; therefore be it

Resolved, that the officers and members of Hudson County Medical Society mourn his passing, and be it further

Resolved, that these resolutions be inscribed upon the minutes of this meeting, and a copy, suitably engrossed, sent to his beloved family, to whom the Society offers its sincere sympathy.

Whereas, It is with deep sorrow that we, the members of Hudson County Medical Society, learn of the passing of DR. THOMAS MCG. BRENNOCK, a valued member and friend, who, in recognition of his active interest in all matters pertaining to the medical profession in general and to this Society in particular, was honored by election to the secretaryship, vice-presidency and presidency of Hudson County Medical Society, and as a delegate to The Medical Society of New Jersey for a period of twelve years, and

Whereas, by reason of his scientific attainments, he was enabled to serve competently as chairman of the Scientific Program Committee of The Medical Society of New Jersey, being a Fellow of the New York Academy of Medicine, a Fellow of the American Medical Association, a Fellow of the American College of Surgeons, attending gynecologist at Medical Center, Jersey City, surgeon at Margaret Hague Maternity Hospital, Greenville Hospital and Fairmount Hospital, all of which he served with fidelity and loyalty, and

Whereas, his personality and enthusiasm were an inspiration to all of us; therefore be it

Resolved, that we record upon the minutes of this meeting the loss we have sustained, and be it further

Resolved, that a copy of these resolutions, suitably engrossed, be forwarded to his bereaved family, to whom we sympathetically offer our consolation.

The following were elected to membership: DR. HUERTA C. NEALS of Jersey City, and DR. RICHARD MANSFIELD of West New York.

A motion was regularly made, seconded and carried that the secretary cast one ballot for the election of the nominees whose names were listed in the report of the Nominating Committee made at the March meeting; for the presidential nominee who succeeds the late Dr. Nalitt, DR. RAYMOND S. DRISCOLL; for the members of the Nominating Committee to serve in 1948, who were nominated from the floor at the April meeting; and for the additional delegates to the annual meeting of The Medical Society of New Jersey, to serve for a period of three years, to 1950—DR. EMILIE RUNDLETT, DR. EDWARD N. BOOKRAJIAN and DR. ANTHONY J. BALSAMO.

The Scientific Session consisted of a symposium arranged by DR. HAROLD W. DARGEON, Chief of Children's Tumor Service at Memorial Hospital; Associate in Pediatrics at St. Luke's Hospital; Director of Pediatrics at Knickerbocker Hospital—comprised of the following: *The Control of Cancer in Childhood,* HAROLD W. DARGEON, M.D.; *Asymptomatic Thoracic Surgical Tumors,* WILLIAM L. WATSON, M.D., Attending Surgeon, Thoracic Surgical Service, Memorial Hospital; *Recent Advances in the Treatment of Leukemias and Lymphosarcomas,* LLOYD CRAVER, M.D., Attending Physician, Memorial Hospital, Assistant Professor of Clinical Medicine, Cornell University Medical College.

WOMAN'S AUXILIARY

OFFICIAL VISITS

A visit of reciprocation with the Woman's Auxiliary to the Medical Society of Pennsylvania will inaugurate your president's series of official visits this fall. This will take her to Pittsburgh on September 15 and 16, and she will then go to Woodbury, N. J., for the session of the Gloucester County Auxiliary on September 19. Five visits are scheduled for October, starting with October 6, Hudson County, then October 10 when the president will conduct the Executive Board meeting in Trenton and later the same day attend the session of the Atlantic County Auxiliary. On the 20th of the month there will be a visit to the Passaic County Auxiliary and on the 27th a meeting of the Essex County Auxiliary. In addition, plans are developing for organizational visits in the early fall to the counties where no Auxiliaries exist.

PRESIDENT'S MESSAGE

MRS. LODOVICO MANCUSI-UNGARO, President

As the Woman's Auxiliary to The Medical Society of New Jersey enters into its activity of the fall it is the wish of all its officers that it prove to be a year for the development of greater usefulness to the Medical Society, and that the county auxiliaries further their sphere of influence in the communities which they serve.

A program at a state level has been put on, not only as a pattern, but that we take our rightful place among women's organizations of the state. All the officials of the auxiliary stand united on this principle, and are ready, at all times, to help if called upon.

The wife of a physician, by virtue of her husband's profession, is a leader in every phase of community life. Therefore, it is the obligation of the Auxiliary to strengthen and broaden this leadership, at all levels, and the obligation of all eligible women to join in this work.

HYGEIA

MRS. NORMAN NATHANSON, Chairman

Every day new horizons are discovered in the battle against disease and it has become the duty of every intelligent person to understand the problems of health and their solutions.

The Woman's Auxiliary to the American Medical Association should be the leader in stressing the importance of knowing health problems. It is the primary way for the laymen to fight disease in league with the medical profession.

Hygeia, published by the A.M.A. has a message for the world today. It teaches enlightenment through qualified educators and doctors, written in a style that is easy to understand.

SUGGESTIONS FOR COUNTY CHAIRMEN

1. Place *Hygeia* into the libraries of the high schools in New Jersey. This will be done if each county chairman requests that its members vote to allot a sum of money from its treasury to do the job in their county. How better can the Auxiliary spend its money than by promoting health education sponsored by the doctors?

2. Introduce *Hygeia* to clubs and organizations.

3. Send subscription blanks made out, together with the money, to Frank V. Cargill, 535 North Dearborn Street, Chicago 10, Illinois.

LEGISLATIVE PROGRAM 1947-1948

Mrs. Oswald R. Carlander, Chairman

Pre-requisite: "The Woman's Auxiliary, county, state, and national must be guided by its Advisory council and the legislative committee of the medical society to which it is an auxiliary organization in all matters relating to legislative activity."

Goal—Every member an informed member on pending or proposed health legislation at the state and national levels.

SOURCES OF INFORMATION

1. Copies of bills pertaining to health measures discussed in the A.M.A. or State Journals. Your congressmen and state legislators can furnish these.

2. The *Journal* of the American Medical Association, sections on legislation and the Washington Letter.

3. The Journal of The Medical Society of New Jersey, section on legislation and the editorials.

4. The *Bulletin* of the Woman's Auxiliary to the American Medical Association.

5. Medical-Surgical Plan of New Jersey, 31 Clinton Street, Newark 2, New Jersey, can supply literature.

6. *Implementing the National Health Program of the American Medical Association in New Jersey.* This brochure describes eleven principles of cooperation adopted by The Medical Society of New Jersey in working with health and welfare societies in New Jersey. (Obtainable at the Society's Executive office in Trenton).

7. Council on Medical Care, c/o American Medical Association, 535 Dearborn Street, Chicago 10, Illinois. Significant excerpts from bills concerning health are sent to your state legislative chairman who will forward them to county legislative chairmen.

8. *Check and Double Check,* by Weston Walsh, published by the Public Relations Bureau of the Medical Society of New York. This booklet is a 'must' for every physician's wife because it answers fairly and effectively most of the questions on voluntary medical care as opposed to the controlled practice of medicine. The State Auxiliary hopes to purchase a copy for each member. If your county medical society approves, a copy of this pamphlet for key lay people in your community would be very helpful and no doubt enlightening.

PREPARATION

1. Know your congressmen from your own district and your representatives in the state legislature and note how they stand on health measures introduced.

2. Be familiar with the practical working of politics.

3. *Suggested reading:* "The Great Game of Politics" by Frank R. Kent, (Doubleday, Page and Company). Also, "History of the American Medical Association" by Morris Fishbein, M.D., published by Saunders, and "How the Medical Association Functions", Vol 8. March 1947, Number 3, *Bulletin* of the Woman's Auxiliary to the A.M.A.

TECHNICS

1. Present a brief summary of current legislation at general meetings of membership.

2. For variation, an auxiliary with ingenuity might write a skit bringing out the views of organized medicine on recent health bills.

3. Schedule meetings with speakers on legislative trends in health education, sickness insurance, etc. The speaker should be a doctor approved by your county medical society. Members should study the issues in advance, in order to ask intelligent questions during the discussion period. The program should be purposeful and not just another meeting.

4. Cooperate with your public relations chairman. If a special meeting on legislation is not feasible, a brief comment on the American way of practicing medicine by the president of your county medical society, or his representative, at a public relations forum is a tactful way of keeping the views of organized medicine for better health before the public.

5. Panel discussions or debates, using the bibliography above mentioned are good media to hold the interest of the audience.

6. True and false tests on *Check and Double Check,* with a small prize for the highest score, will be informative and enjoyable for your membership.

7. Study groups: Breakfast or luncheon meetings may be followed by thorough study of a topic suggested by the bibliography.

8. Quotations of vital points from bills pertaining to health legislation that are of particular interest to organized medicine.

The goals, sources and means of achievement in health legislation are not basically different from those of other years. They afford us, as always, the opportunity to protect and promote the cherished ideals of the medical profession which places service to humanity above every other consideration.

ORGANIZATION

MRS. C. CHESTER CHIANESE and MRS. THOS. P. MCCONAGHY

Our parent organization issued for our assistance, a *Handbook,* a copy of which should be in the hands of every Auxiliary member. According to the *Handbook,* the Committee on Organization has a two-fold purpose:

1. To increase membership in the Woman's Auxiliary.
2. To organize county auxiliaries.

We urge county chairmen to perfect their county organization by:

(a) Listing members who have dropped out and making an effort to interest them in reinstatement.

(b) Securing a list of eligible non-members from the secretary of the county medical society and inviting them to join.

(c) Requesting the county officers to provide time on one program annually for a speaker from the state board of directors of the Woman's Auxiliary who will present interesting features of auxiliary work.

(d) Inviting doctors' wives from adjoining unorganized counties to this meeting and urging them to become members-at-large, if no county organization is possible.

It is believed the above suggestions (a), (b) and (c) are followed by all county chairmen, but does each county follow suggestion (d)?

Increase in county membership is vitally important and may be secured through friendliness, sociability, worthwhile projects, and by membership teas, a ladies' night, or a dance. Each county should elect the methods most adaptable to its own particular need.

When a new member is secured, a good county chairman will help her become acquainted with other members, and keep her informed of Auxiliary work. Interested and active organization members are always an asset.

The committee could be so divided that every new member would be contacted by phone or otherwise, preceding every meeting and urged to attend, and when attending, be accompanied by this committee member, thus accomplishing our first objective, i. e., friendliness and sociability.

The unorganized counties are being reached with the hope that additional counties may be organized, and members-at-large be secured in those counties not organized.

SUGGESTIONS FOR COUNTY PROGRAM CHAIRMEN

MRS. JAMES H. MASON, Chairman of Program

1. Have your programs sufficiently interesting so that new members may be attracted and attendance increased at each meeting.

2. Strike a happy balance between social and educational programs.

3. Call a meeting of all "subject matter" chairmen in the county. Plan, with them and your county president, the year's work.. If each chairman assumes responsibility for one meeting, all activities will be included and a well rounded, correlated program will result.

4. Stress auxiliary projects such as promotion of *Hygeia,* public relations, health legislation, etc., with the approval, of course, of your County Advisory Council.

5. Feel free to call on your state chairman for any assistance you may need.

Best wishes for "pithy and peppy" programs.

PUBLIC RELATIONS

MRS. ASHER YAGUDA, Chairman of Public Relations Committee

The tentative plans of the Public Relations Committee are:

1. Cooperation with the State Department of Education, requested by Dr. Wilson G. Guthrie, Director of Health, Safety and Physical Education of that department, in organizing the school physicians, nurses, dentists, psychiatrists and other approved persons, towards a better school health program. A consulting committee, at a state level, is being formed. All actual work, in connection with this program, is to be carried on by the public rela-

tions committee of the State Auxiliary and the result submitted to the county auxiliaries as a suggested procedure for this organization. This is to be set up at a county level, as requested by Dr. Guthrie.

2. Presentation of *Rural Health Programs* with simultaneous programs in the one-room schools and the local Grange. Speakers for these programs are to be Auxiliary members, trained for the purpose and presenting health talks which have full approval of the Advisory Board.

3. Establishment of a state wide goal (operating at county level) of a health committee in every lay organization in the state, with every chairman an auxiliary member.

4. Broadcasts of health talk "platters" prepared (and obtainable without charge) by the Health Education Bureau of the American Medical Association.

WIDOWS AND ORPHANS

MRS. ERNEST F. PURCELL, Chairman

Are you a member of *The Society for the Relief of the Widows and Orphans of the Medical Men of New Jersey?*

Through this society, we can not only find an added sense of security for our own dependents, but have the privilege of helping others in the medical profession, by bringing immediate financial aid to the dependents of a deceased member.

Any member of The Medical Society of New Jersey is eligible for membership.

We urge each county chairman to explain the details of this helping hand society to their membership.

Application blanks and further information can be secured through your state chairman.

BOOK REVIEWS

The Albee Memorial Issue of the Journal of the International College of Surgeons. January, 1946.

No student of the history of the crippled and disabled can fail to note the emergence of the status of the physically handicapped in the twentieth century from one of hopelessness to one of opportunity. This opportunity was expressed by the concept of rehabilitation, best epitomized by the philosopher Paulsen, who said, "the object of all help was to make help superfluous". By means of advanced orthopedic methods and devices and the use of education and vocational training, it aimed to develop the residual physical and mental powers of the individual to the point where he could meet the competition of those who were free from physical defects.

In the development of this concept Dr. Fred H. Albee was a leader and pioneer. As Chairman of the New Jersey Rehabilitation Commission for more than twenty-five years, he spearheaded the rehabilitation program into an international movement. Though best known for his pioneering work in bone grafting and the development of special technical devices, his important contributions toward international professional cooperation as well as national legislation on behalf of the physically handicapped cannot be overlooked.

This small volume is a memorial issue of the *Journal of the International College of Surgeons* which he helped to found and develop. In this issue are eighteen articles by colleagues of Dr. Albee in the fields of plastic and orthopedic surgery covering many special and general problems of reconstruction surgery. The high standard of the articles are a measure of the regard and professional tribute paid by the contributors to Albee, the surgeon, the social pioneer, and the man.

H. H. KESSLER, M.D.

Diseases of the Adrenals, by Louis J. Soffer, M.D. 289 pp., 42 engravings, 2 colored plates. Lea & Febiger, 1946, Philadelphia.

Since the monumental work of Addison, great strides have been made in the understanding of the role played by the adrenal glands in the body economy.

This most recent book on the diseases of the adrenals gives a historical review of the subject and brings up to date the mass of clinical observations and precise laboratory tests now used in the diagnosis of suspected adrenal disease.

Of special interest is the elucidation of the role of the adrenals in carbohydrate metabolism and in the physical and psychologic changes in individuals afflicted with adrenal tumors, especially in cases of masculinization and feminization.

There is a detailed chapter on the hormones of the adrenal cortex and their functions as well as description of methods of analysis of urinary excretion of 17 ketosteroids.

Much of the book is devoted to early diagnosis and treatment of acute and chronic Addison's Dis-

ease, and the avoidance and treatment of the crises of Addison's Disease.

There is a discussion of the close interdependence among all the glands of internal secretion; special emphasis is placed on the adrenal glands, because without them the organism cannot survive.

This book is helpful to the clinician and essential for the endocrinologist.

RITA S. FINKLER, M.D.

The Compleat Pediatrician. Wilburt C. Davison, M.D. 5th ed., 256 pages. Duke University Press, Durham, N. C. 1946. $4.00.

The ordinary textbook on pediatrics is divided into disease groups, so that if the practitioner frankly does not know the disease, he has difficulty in finding a category into which the syndrome fits. The "Compleat Pediatrician" however is set up on a novel plan. It is arranged by symptomatic clues. For example, presented with a child whose only symptom is nasal regurgitation, the practitioner can turn promptly to the paragraph in this book so captioned and find, in order of their frequency, the diseases which might be accompanied by nasal regurgitation. After each name is an index number referring the reader to a more complete description of the diseases. This is a new edition of an old pediatric stand-by, and has been brought up to date by the addition of recent information on chemotherapy and tropical diseases and by a revision of older knowledge in the field. The text also serves as a net in which have been caught the prize ideas of modern pediatrics. In its general arrangement, this volume looks something like a cross between a dictionary and a telephone directory; and by the conscientious practitioner, it will be used just as often.

RALPH NEIL SHAPIRO, M.D.

Management of Tuberculosis in General Hospitals. Prepared by the American Hospital Association. Published 1947 by the Association at 18 E. Division St., Chicago 10. 48 pages, $1.00.

A useful manual for coordinating and developing programs for tuberculosis control is offered by the Council of Professional Practices of the American Hospital Association. The brochure is in outline and check-list form and it contains a good deal of "how to do it" information on case finding in general hospitals, technics of isolation and the administration of a tuberculosis control program. The manual is highly practical, giving such details as how to word signs in the tuberculosis department and how to dispose of sputum cups. It also provides a useful framework for discussions and lectures on the subject.

Fundamentals of Clinical Neurology. By H. H. Merritt, F. A. Mettler and Tracy Putnam, 289 pages. Blakiston, 1947, Philadelphia, $6.00.

Although not offered as a definitive textbook of clinical neurology, this slender volume does provide an understanding of the anatomic and pathologic substratum of organic diseases of the nervous system. The first 64 pages constitute a manual of neurologic examination technic, while the rest of the book is devoted to a swift review of neuro-anatomy and neuro-pathology correlated with the clinical symptoms associated with lesions of each region. There is even a brief paragraph on the treatment of the relevant clinical syndromes. Especially useful is a concise chapter on the interpretation of cerebrospinal fluid findings. Neurophysiology receives a somewhat sketchy treatment, and (apparently in the interest of simplicity) controversial matters are omitted. It is a handy manual for the medical student, general practitioner or embryo neurologist.

HENRY A. DAVIDSON, M.D.

Differential Diagnosis of Jaundice. By Leon Schiff, M.D., Chicago, 1946. Year Book Publishers. 313 pages. $5.50.

A correct analysis of jaundice remains an enigma in a small but definite proportion of cases. Any text which offers any clarification of differential diagnosis is a welcome addition to our diagnostic armamentarium. Dr. Schiff has attempted to expedite this problem correlating clinical and laboratory aids in differential diagnosis. He has called upon his vast reserve of experience in the problem of jaundice to offer many timely suggestions.

With the advent of many newer liver function tests, varying in degrees of refinement, but all purporting to aid in the diagnosis of jaundice, it is comforting to find that Dr. Schiff attempts to place them in proper prospective. This book is not a complete presentation of the subject of jaundice since the hemolytic problem is touched on only inadequately; however, since its main concern is differentiating parenchymal from the extra-hepatic obstructive types of jaundice, this minor flaw is excusable.

The busy practitioner as well as the internist could gain profitable knowledge from a careful perusal of this volume.

HERBERT GREENFIELD, M.D.

Concise Chemical and Technical Dictionary. Edited by H. Bennet. Chemical Publishing Co., 26 Court St., Brooklyn, N. Y., 1947. 1120 Pages. $10.00.

Packed into this solid volume is a storehouse of information about newly developed synthetic chemicals, arranged alphabetically with a key to pronunciation. Especially useful to physicians are conversion tables for weights, measures, temperatures and specific gravity. Another handy table lists vitamin values of major foodstuffs. Also catalogued are trade names for many proprietary products. In all, the volume contains compact monographs on fifty thousand different chemicals and chemical combinations including pharmaceutical and biologic terms, as well as those in metallurgic, botanical and chemical fields. It is a prime reference volume for any doctor working in biochemistry, pharmacology, medical physics, pathology or radiology. And it will prove a useful reference work for the physician who believes that, towards fields tangential to his own, ignorance is not bliss.

I. GELBERG, M.D.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **September, 1947** **No. 9**

THAT mortality statistics fail to show the magnitude of the tuberculosis problem in any community is not a new idea. An individual may have been spreading tubercle bacilli for years yet heart disease or an intercurrent infection may account for the terminal diagnosis entered on the death certificate. Pathological reports, when available, give a more accurate measure of the amount of tuberculosis in the population than do vital statistics.

A PATHOLOGIST LOOKS AT TB

The autopsy records for the past ten years at Bellevue Hospital (New York City) reveal some important facts about the tuberculosis problem in this large metropolitan institution. Much of the information in these records is not found in death certificates and hence does not appear in vital statistics.

In the period from 1935 to 1945, 7,631 complete post-mortem examainations were done on individuals over 16 years of age, from all hospital services. One case out of every 10 examined revealed tuberculosis cavitation. Tuberculosis as the cause of death in the whole group showed the highest rate between the ages of 16 and 40. However, two out of three of all the "spreaders" of tubercle bacilli were over 40 years of age, with many of them dying from causes other than tuberculosis. Most deaths from all causes in hospitals are in individuals over 40 years of age. In the epidemiology of tuberculosis the number of cases "spreading" the infection—not the mortality rate within a certain age group—is the important and too often overlooked fact in the attack upon the tubercle bacillus.

The records of the cases with tuberculous cavity formation show that 13 out of every 100 were not recognized clinically. Eight out of every 10 of the unrecognized cases were in individuals over 50 years of age.

The reasons for this situation may be many, but three are outstanding. First, a disease of more serious immediate concern was the reason why the individual became a hospital patient. Second, non-tuberculous lung diseases are more common in older persons which makes a correct diagnosis of tuberculosis more difficult. Third, the old dictum that serious tuberculosis is rarely acquired after 40 years of age has tended to dull medical thought about this disease in older persons unless there is a history of tuberculosis. A case with a cancer and a tuberculous cavity may die from the cancer but the spread of tubercle bacilli can be just as effective as if the whole process were tuberculous in nature. From these data, it is easy to see why the program to X-ray the chests of all hospital admissions and out-patients is of great importance.

The tuberculosis problem in a hospital may not truly reflect that of the community, for only those with serious illlness will be represented. For the past two and one-half years an opportunity has been given to examine all cases of unexpected deaths, including deaths from accident, from suicide, from homicide and from obscure causes in Manhattan. The group is a representative cross-section, though small, of the inhabitants of New York City.

In this discussion, only the presence of tuberculous cavity will be considered, for this group represents the "spreaders" of the tubercle bacillus. In a group of 1,235 adults over 20 years of age, tuberculous cavity formation was observed in one of every 20 cases. No tuberculous cavity was found in 100 individuals under 20 years of age. One in every 16 white males, one in every 24 Negro males, one in every 30 Negro females and one in every 116 white females showed tuberculous cavity formation. In this group, open tuber-

culosis with cavity was present four times more often in the adult male than in the adult female. In males over 30, six out of every 100 showed the presence of tuberculous cavity.

From these few figures, an idea of the tuberculosis problem on this congested island is obtained. The individuals in the group examined represented many occupations—salesman, waiter, porter, housemaid, truck driver, bartender, elevator operator, auditor, clerk, gangster, etc. Supposedly they were well and at work yesterday—today they are found dead. Among them, it was unusual to unearth a known tuberculous case. The cause of death given by the Medical Examiner's Office reveals that in only one-fifth of these cavity cases is tuberculosis set down as the cause of death.

This shows how an erroneus idea may be obtained with regard to tuberculosis when data from death registration receive undue weight. This also shows that if X-ray surveys are to be effective, every adult, especially all males, in a community should be included.

The socio-economic problem presented by the above figures looms large. It is the breadwinner who is most often infected. Those who mingle most in masses of humanity are the ones who most frequently contract a serious infection and who spread the infection most. No adult age group escapes and the problem of tuberculosis control demands maximum efforts to prevent exposure of adults to infection.

The decrease in tuberculosis in the very young has led some to believe that, if we can rear a population free from tuberculous infection, the problem of tuberculosis will be solved. No reasoning could be more unsound. There is plenty of evidence that young adults with negative tuberculin reactions can die from an infection acquired in adult life.

In the solution of the problem of tuberculosis the fullest cooperation of an enlightened public opinion is urgently needed. Any community with pride in the health of its citizens; with a compassion for those who, through no fault of their own, become ill; and with sure justice for those recalcitrants who knowingly endanger others can go far in the struggle against the tubercle bacillus. The crucial battle has barely begun. Let us see it through to success.

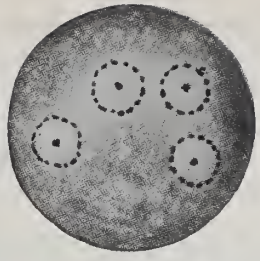
A Pathologist Looks at TB, Edgar M. Medlar, M. D. Bulletin of the National Tuberculosis Association, January, 1947.

SUPPLIED BY

New Jersey Tuberculosis League

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— Proc. Soc. Exp. Med. 64:393, 1947.



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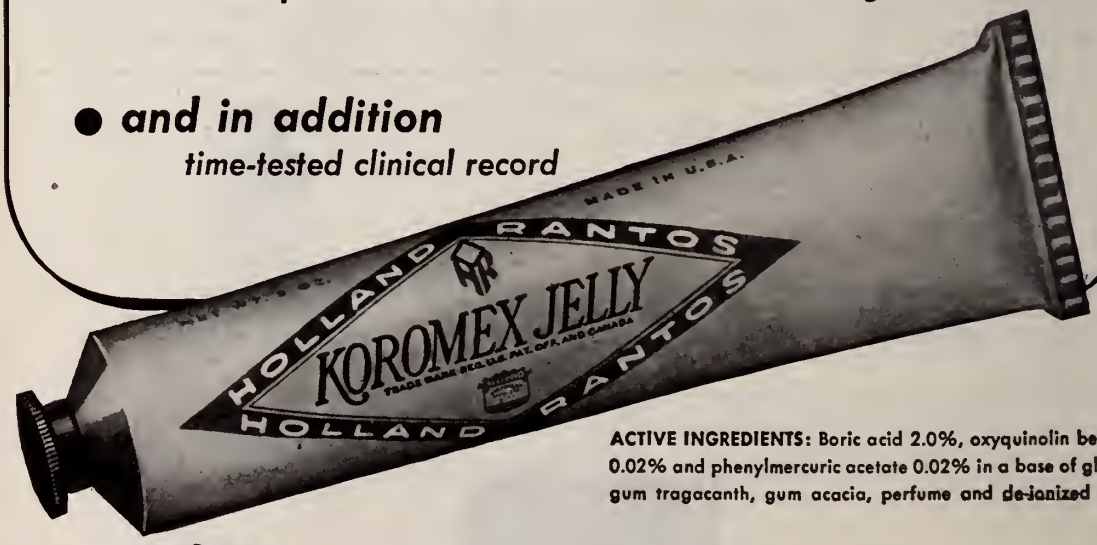
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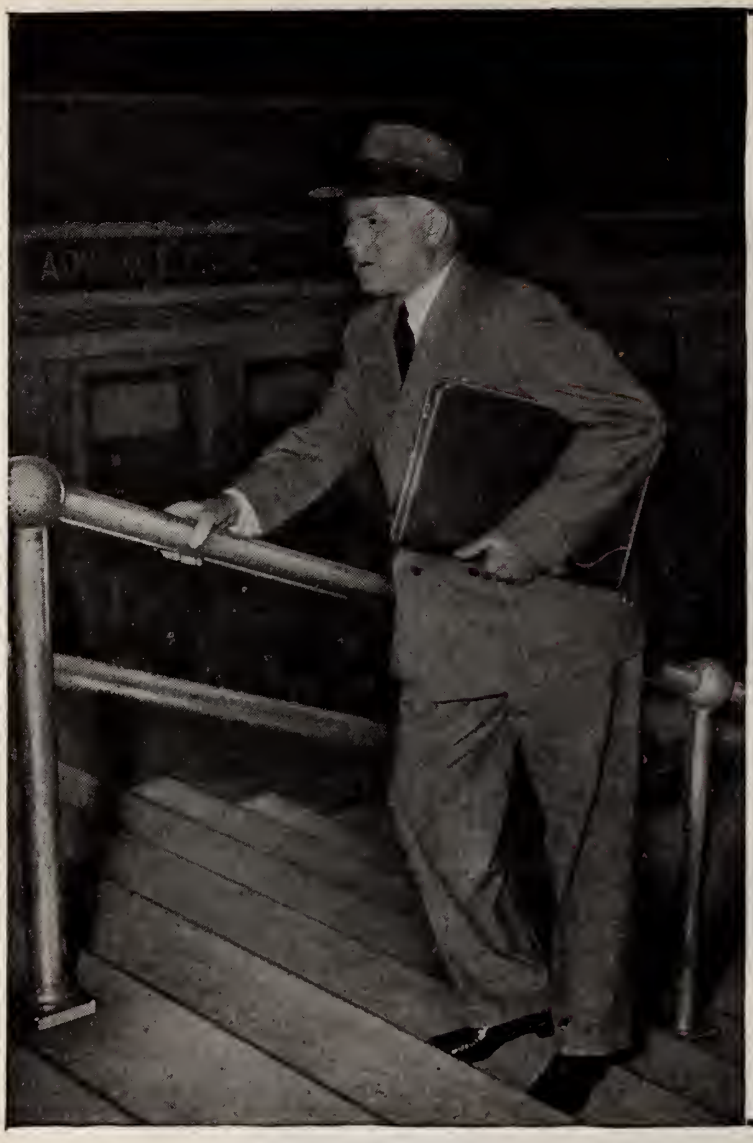
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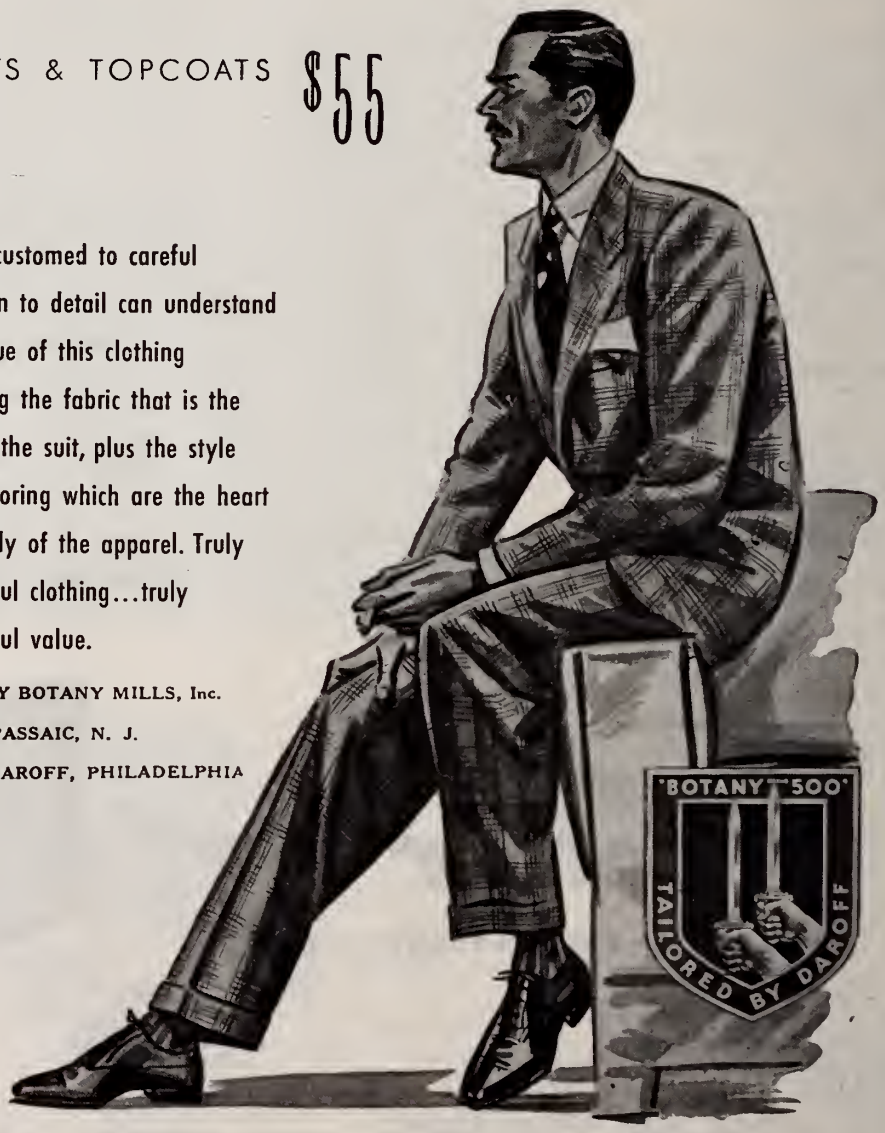
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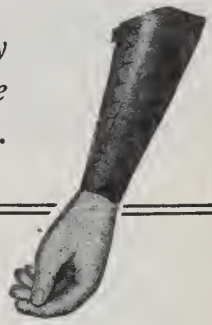
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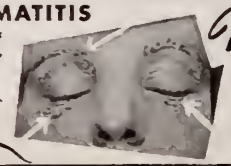
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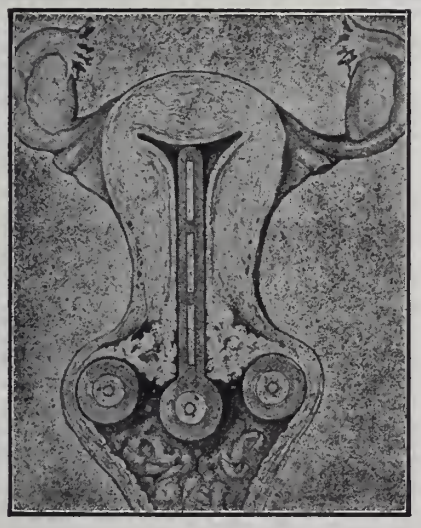
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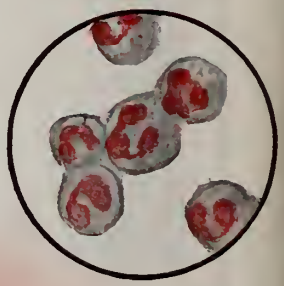
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1. Lennox, W. G. (1947), Tridione in the Treatment of Epilepsy, J. Amer. Med. Assn., 134:138, May 10. 2. DeJong, R. N. (1946), Further Observations on the Use of Tridione in the Control of Psychomotor Attacks, Am. J. Psychiat., 103:162, Sept.

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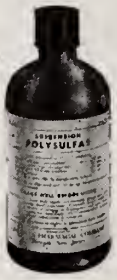
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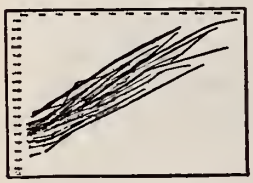


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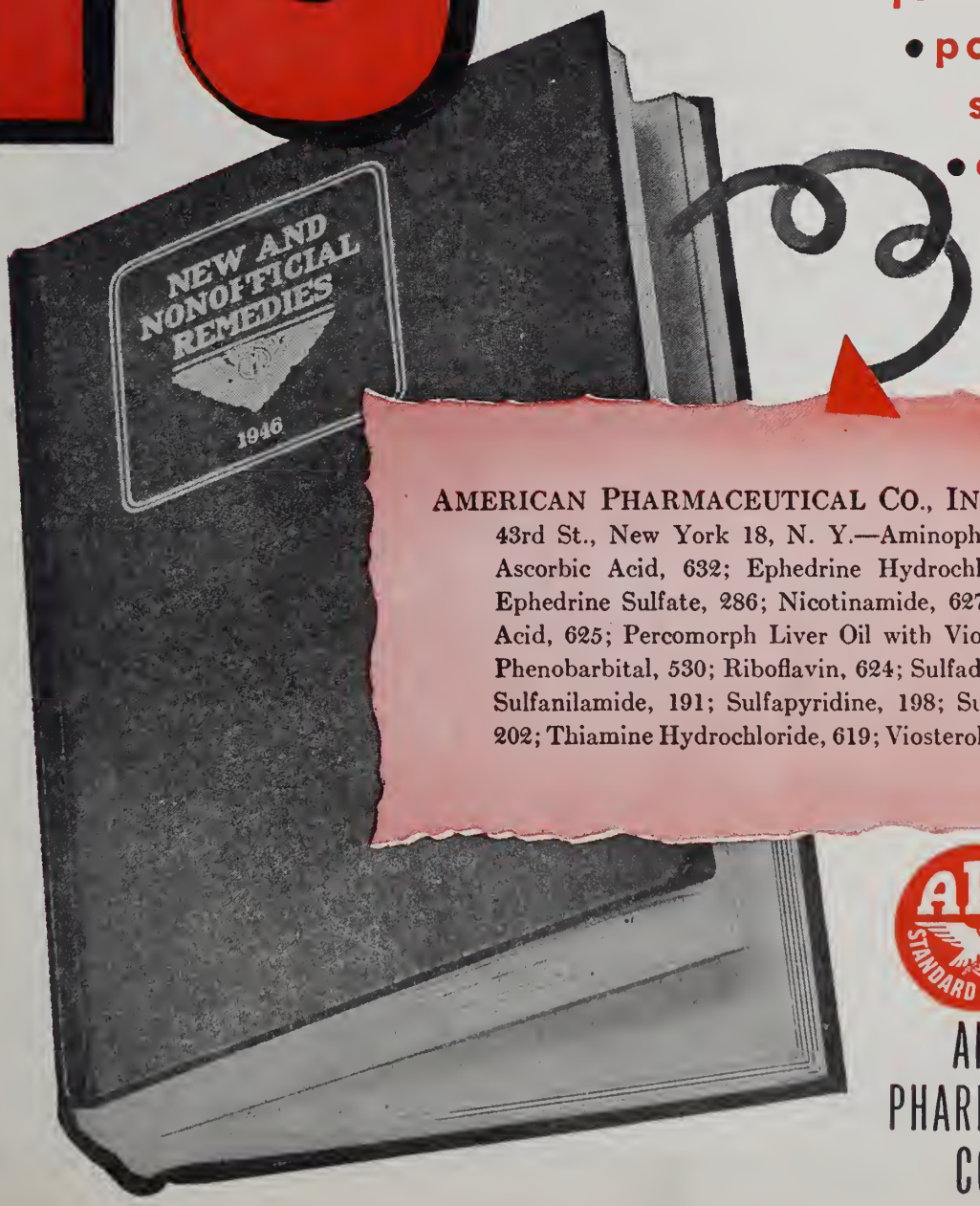
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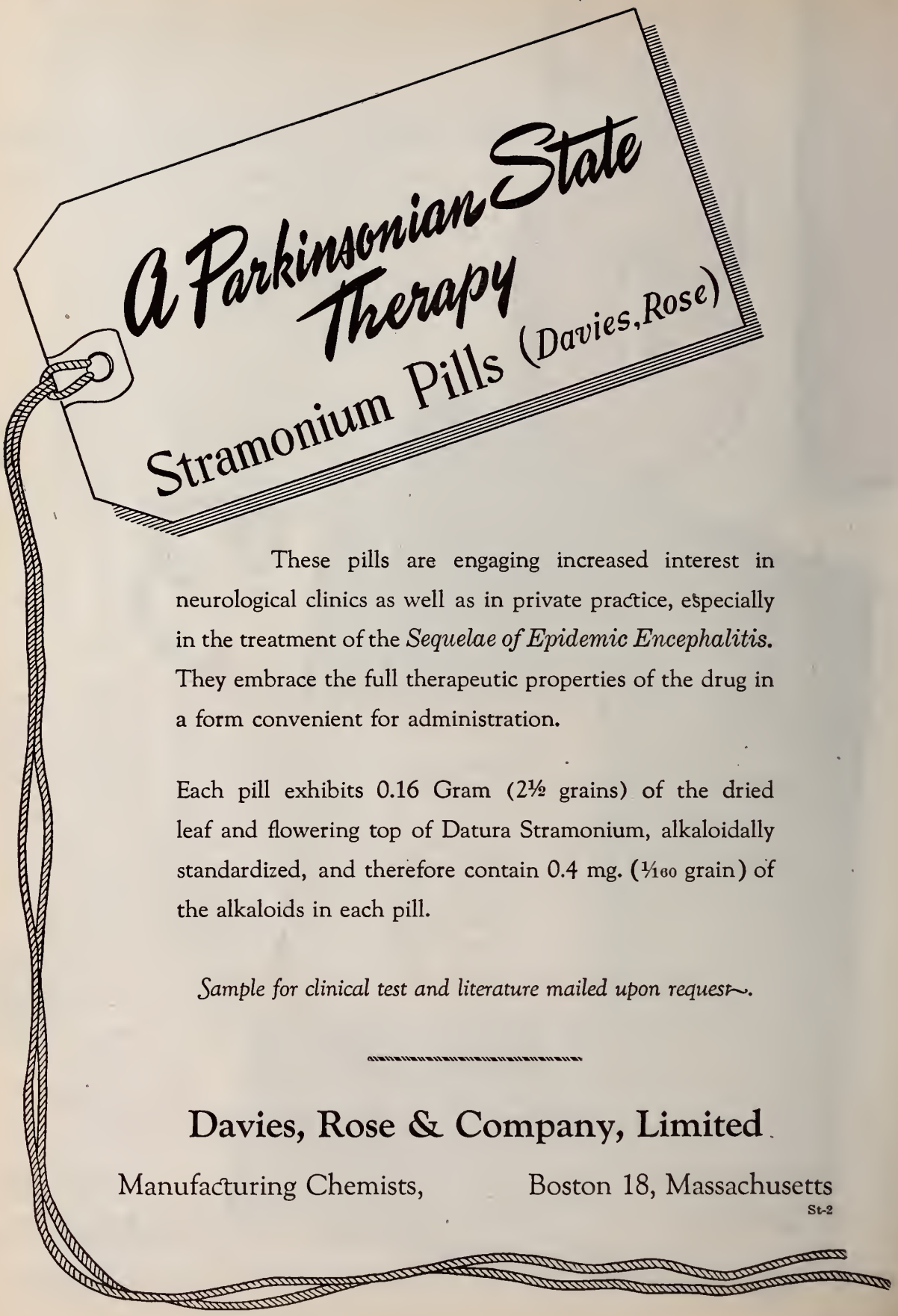
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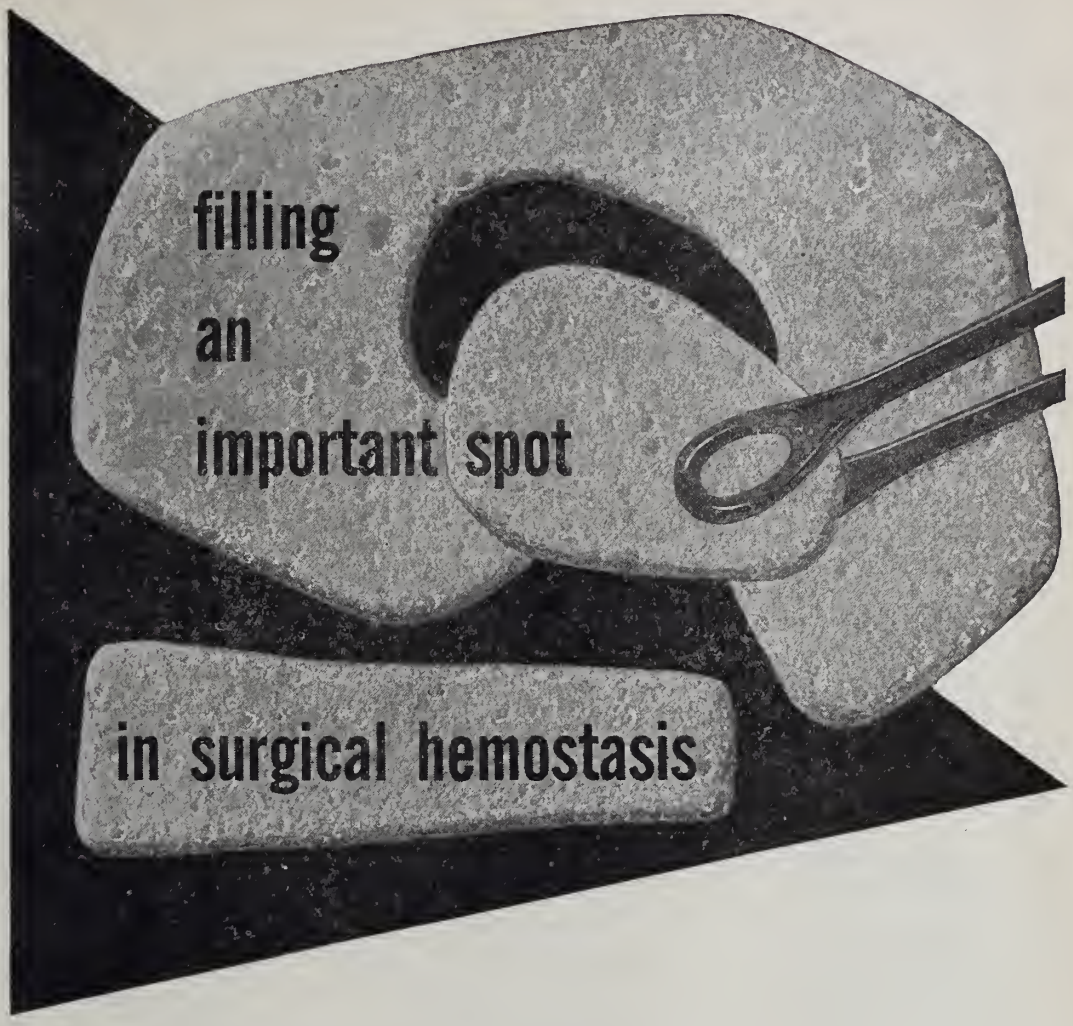
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*Feinberg, S. M.: J.A.M.A., 132: 702 (Nov. 23) 1946.

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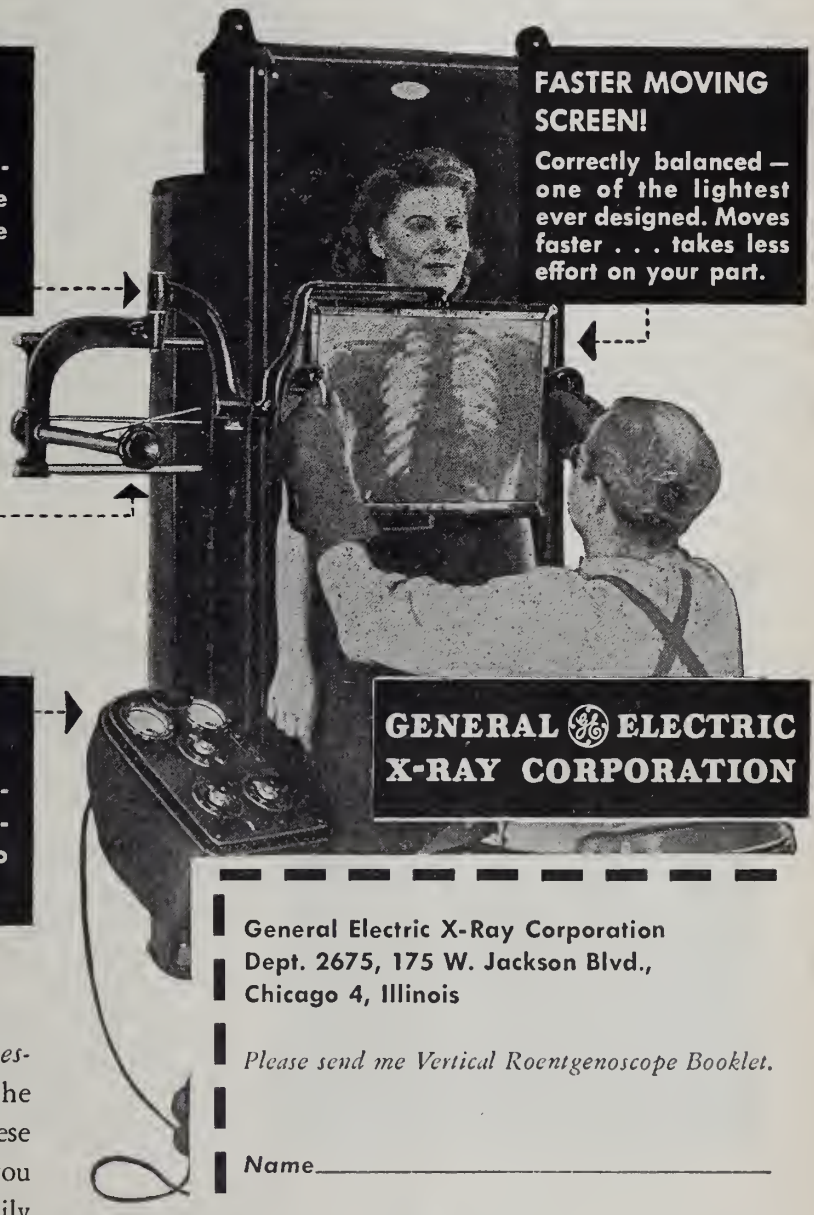
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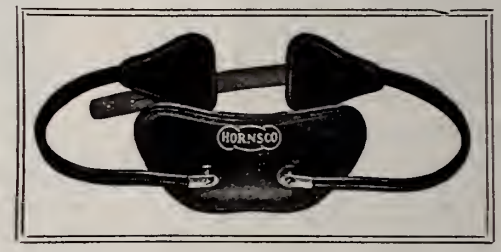
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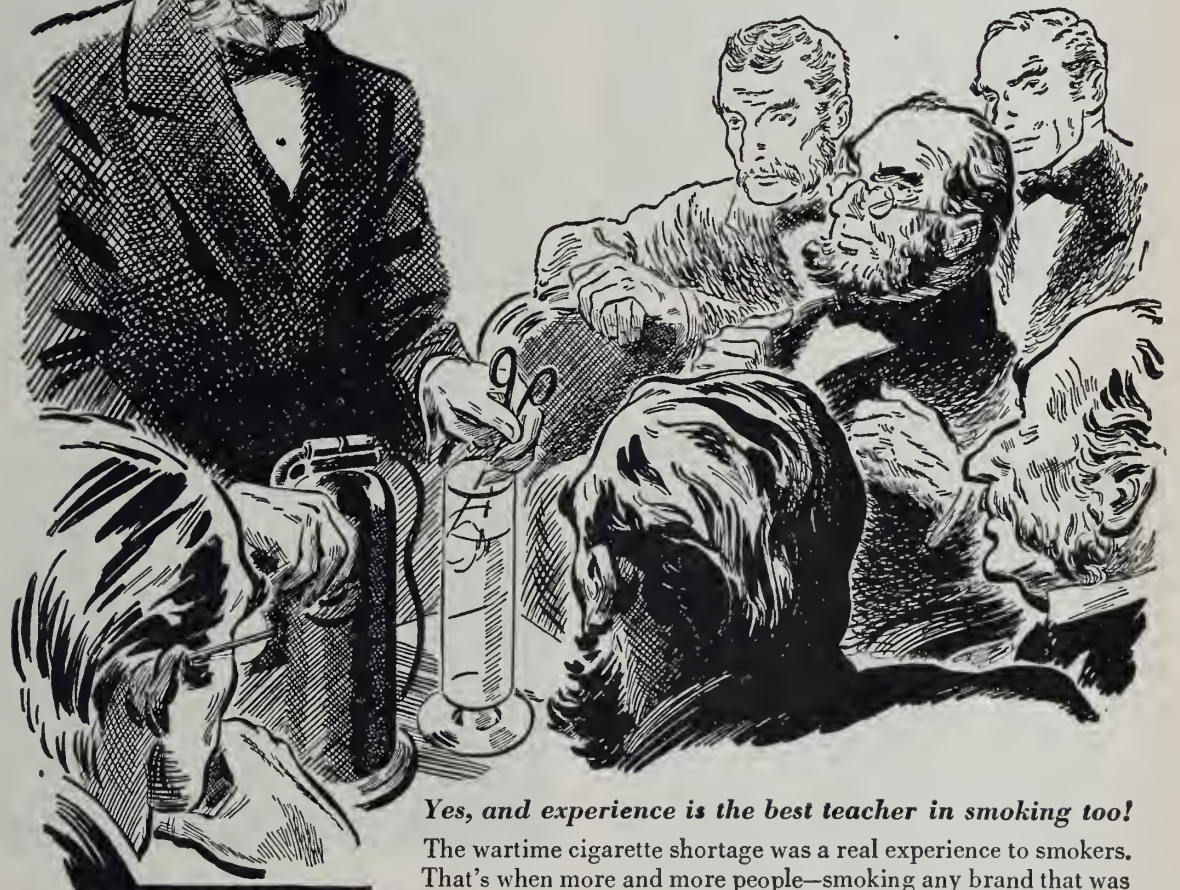
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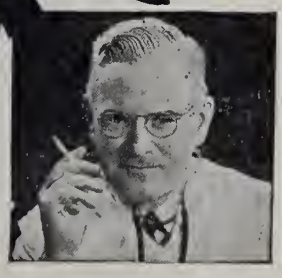
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*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

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1. Feinberg, S. M.: Quart. Bull. Northwestern Univ. M. School 20: 398 (1946)

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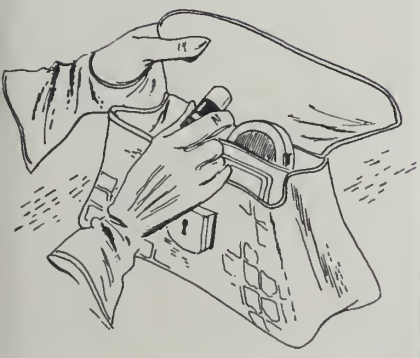
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PHYSICIANS are familiar with caisson disease, the industrial hazard encountered in construction of bridges, tunnels, and skyscrapers where workers breathe air under pressures of more than one atmosphere.

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OF
THE MEDICAL SOCIETY OF NEW JERSEY

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THE PRESIDENT'S PAGE

THE WOMAN'S AUXILIARY

When the proposal to organize a Woman's Auxiliary to The Medical Society of New Jersey was first broached twenty odd years ago, it was greeted with a smile, a lifted eyebrow or outspoken skepticism in many quarters. Some of our more vociferous members derided the idea and actively opposed it. Few of us then appreciated the immense benefits to organized medicine which an active and intelligently directed Auxiliary could contribute. Much water has flowed over the dam in the intervening years and the Auxiliary is now firmly established as an essential and integral part of our Society. The Auxiliary began primarily as a social organization but with the passage of years, additional activities increased its scope until at present it is an indispensable agency of the Society as a whole, but particularly in the field of Public Relations.

To point out the value of the state and county Auxiliaries in securing and retaining the good will of the general public toward organized medicine, I need only mention the medical exhibit in Essex County in 1940 which was largely the work of the Essex County unit and which drew nearly 50,000 people to the exhibit hall in one week; the success of the blood bank in Ocean County which was an Ocean County unit project, and the brilliant success of the Health Round Table Conference in Trenton on June 16, 1947. The transactions of this Conference were fully reported in the August 1947 Journal but the cold print fails to convey the great interest and enthusiasm which prevailed, not only among the participants but also in the audience. At the summation in the afternoon the SRO sign was up and attentive listeners were standing in the hall

outside our large meeting room. This Conference demonstrated the eagerness with which the general public will participate in activities of our Society which are directly or indirectly concerned with the public welfare. I wish to express our gratitude to Mrs. Lodovico Mancusi-Ungaro, President of our State Auxiliary, to Mrs. Asher Yaguda, Chairman of the Auxiliary Public Relations Committee and to the large group of loyal co-workers who planned and executed this unusually successful venture in Public Relations.

In spite of the excellent work which has been done by so many County Auxiliary groups, eight of our component county societies have not yet availed themselves of the public relations possibilities inherent in a County Auxiliary. Too few of us appreciate the time, effort and unselfish service which the officers and members of our Auxiliary have devoted to the welfare of organized medicine. Nothing seems too arduous or formidable for them to undertake and to carry to a satisfactory conclusion.

It is my considered opinion, after long and varied experience in the field of medical public relations, that our state and county Auxiliary units are our most effective public relations agencies. I strongly urge those component societies which do not now have an Auxiliary unit, to avail themselves of the help which these devoted women are so able and willing to contribute to the general welfare of organized medicine.

Royal A. Schaaf, M.D.
President.

REJUVENATING THE MEDICAL CORPS

Because of the low pay schedules and the uncertainty of professional growth, the Army in peace-time has always had difficulty in attracting young and ambitious physicians. Doctors interested in government service usually prefer the dynamic professional atmosphere of the U. S. Public Health Service. The vigorous training program of the revitalized Veterans Administration, combined with the pay increment offered to board diplomates, and the relative assurance of fixed geographical placement have combined to make the VA more attractive than the Army to both mature physicians and younger practitioners.

Faced with an anticipated shortage of more than 3000 doctors in its medical officer requirements, the Army has welcomed the introduction of S-1143 (HR 3174) which lays down a four-point program designed to make the military service more attractive to physicians. As outlined by Secretary Patterson in Atlantic City last June, the bill provides for a flat pay increase of $100 a month to medical officers (giving them that much more than line officers of the same grade), establishment of professorships at the Army Medical Center, direct appointment of senior civilian physicians to high rank within the medical corps, and a 25 per cent pay increment to board diplomates.

Some physicians may complain that these provisions do not touch the grievances most often outlined in last year's AMA questionnaire on the subject. Chief complaint then was the allegation that final authority, even over health and medical problems, rested with line officers rather than in the hands of physicians.

The proposed legislation is silent about changes in this direction. But in the last analysis it is difficult to see how an Army could function efficiently if specialists who are not accountable for overall results, were given fundamental policy-making authority. A line officer is answerable to the country for winning

and losing battles, and must therefore have the right to pass on his own manpower requirements. Indeed, to give medical officers this kind of policy-making power would be to saddle them with administrative duties, which is exactly what doctors don't want.

It is the medical officer's job to give health and sanitary advice, the line officers's job to accept—or reject—this advice, to implement the suggestions if the advice is acceptable, to bear the responsibility if the recommendations are rejected. To doctors prepared to accept this limited role, to doctors who see that staff functions and command authority are quite different, the proposals of Secretary Patterson will be attractive. Certainly the bill as enacted will now improve opportunities for professional advancement within the Army, and will make the financial returns less grotesquely disproportionate to the dollars-and-cents emoluments of private practice. The new law however will not give the medical corps any veto authority over command decisions. The physician who cannot adjust to an authoritarian framework will still prefer private practice.

TACTICS AND STRATEGY IN HEALTH INSURANCE

At the September meeting of the Welfare Committee, Marjorie Shearon, Ph.D., delivered a talk on the "Welfare State" which approached the problem of health insurance from a novel point of view. The talk, published in extensive abstract on page 413 of this issue, directs itself at the motives of the proponents of compulsory health insurance, rather than at the defects in their plans. The feature of this approach is that it views the problem strategically not tactically. By contrast, most practitioners, whether in favor of health insurance, or opposed to it, take an essentially tactical point of view. Thus, advocates of compulsory health insurance ordinarily look for statistics which support their contention that medical care is now inadequate; or they elaborate on the machinery of the many ambitious projects for furnishing medical care. Those who resist compulsory insurance point out the fallacies in reasoning from statistics or underline the many defects in the plans for compulsory health insurance which have already been presented. In either case, it is an argument on the merits or defects of a plan. Similarly, those who want to see compulsory insurance written into the law, use the normal propaganda and lobbying activities available to any one with a cause, while those of us who are opposed to it, seek to meet these arguments one by one. Thus, the usual approach is by way of tactics—promotional, political or parliamentary.

Dr. Shearon's method of viewing the problem is intriguingly different. She feels that the prime requisite is an understanding of the motives behind health insurance propaganda. While she writes no prescription for the counter-attack, it may be assumed that a public exposure of this motivation would represent sound strategy for opponents of health insurance. Some would question the effectiveness of a technic which attacks motives rather than merits. Since at least a few men of good will have endorsed health insurance, it may be that an assault on motives would simply consolidate their forces. Such men are, from this point of view, to be considered innocent dupes: a status which no one wants to admit he occupies. A reasoned and temperate criticism of the merits of the plans would seem to be more in keeping with the strategy of a professional organization.

ORIGINAL ARTICLES

PULMONARY EMBOLISM AND VENOUS THROMBOSIS

DIAGNOSIS, PROPHYLAXIS AND TREATMENT*

Robert R. Linton, M.D., Brookline, Mass.

Sudden death from massive pulmonary embolism has been considered by most surgeons until recent years the inevitable outcome of major surgical procedures in a certain proportion of patients. In our clinic, the incidence of fatal embolus was reduced to approximately one in 800 surgical patients, using methods of preventing venous stasis by posture combined with early passive and active exercise. It was nevertheless discouraging to find that the patients who succumbed were frequently those who seemed to be making the most uneventful and uncomplicated convalescence. The surgeon was also confronted by the terrific morbidity of thrombo-embolic disease, since all the conservative methods of treatment necessitated a prolonged period of bed rest and hospitalization. It is also realized that not only are surgical patients so afflicted but also many individuals suffering from non-surgical diseases.

Venous thrombosis with pulmonary embolism is most commonly seen following major surgical procedures, trauma to the extremities, severe illnesses (such as typhoid fever and pneumonia) and chronic illnesses (such as cardiac disease) which require long periods of bed rest.

SITE OF ORIGIN

The deep veins of the calf are the most common site of origin from which thrombosis propagates into the large veins of the leg and thigh. In a few cases thrombosis may originate in the veins of the broad ligament and pelvis with propagation into the iliac and femoral veins. The fatal embolus practically always originates from these large venous channels.

ETIOLOGIC FACTORS

Thrombo-embolic disease occurs most frequently in patients over 40 years of age. In a group of 202 patients with this condition, 82 per cent were 40 years of age or older. The highest incidence was in those beyond 50 years of age who had had an abdominal or pelvic operation for malignant disease. With a better understanding of the etiologic factors, the early diagnosis, prophylactic measures which may be utilized, and the prevention of fatal pulmonary embolism by interruption of the venous channels from the lower extremities, it is believed possible to prevent practically all cases of fatal pulmonary embolism.

The exact cause of venous thrombosis is still obscure, but it has been definitely established that the condition is most common in patients beyond middle life. Another important factor is the immobility of the extremity following major abdominal operations, accidents to the lower extremities, or from serious illnesses. Any condition which favors venous stasis of the extremity, (such as abdominal distention, tight abdominal binders, pressure on the popliteal space from pillows or elevation of the bed, or tight bandaging of the thighs without inclusion of the lower leg) will predispose to intravascular thrombosis of the lower extremity. Constitutional conditions, such as obesity, anemia, the presence of acute infection, are additional factors. Venous stasis undoubtedly is the most important item which seems to favor spontaneous thrombosis, so that whenever possible, measures should be taken to prevent venous stasis.

PATHOLOGY

In general, there are two types of venous thrombosis — the adherent or obstructing thrombophlebitis, and the silent or non-obstructing venous thrombosis, for which Ochs-

* From the Dept. of Surgery, Massachusetts General Hospital, Boston, Mass. This paper was read, by invitation, at the Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 22, 1946.

ner has popularized the term "phlebothrombosis". The former is considered to represent a late stage of the disease. The extremity, in addition to swelling, usually shows a moderate degree of cyanosis and dilatation of the superficial veins. There is usually marked tenderness in the calf and along the course of the femoral vein in the thigh and groin. Unfortunately, many physicians are reluctant to make the diagnosis until this classical picture of late phlebitis is seen. Most patients who develop the type with a swollen, tender leg, however, give an antecedent history of pain in the calf before the entire leg becomes swollen and tender. While fatal pulmonary embolism rarely occurs with this type, measures should be taken in every case to prevent it. The second type is more treacherous because it produces so few symptoms and yet potentially there is greater danger from fatal pulmonary embolism. The main portion of the thrombus, which lies in the popliteal and femoral veins, is frequently nonadherent to the vein wall, so that it is floating like a long tail in the venous stream. This large, unattached clot, when it breaks off, may be swept upwards to the heart occluding the pulmonary artery and producing sudden death.

The relationship of deep venous thrombosis to pulmonary embolism has long been established. In 95 per cent of the cases, pulmonary emboli can be traced to the leg veins. In a recent study at the Massachusetts General Hospital, it was found that one out of three patients with deep venous thrombosis had a minor pulmonary embolus and one out of four with a minor embolus died from a massive embolus, a mortality rate in this group of 25 per cent. These figures emphasize the necessity of early recognition of deep venous thrombosis, so that measures can be taken to prevent death from pulmonary embolism.

DIAGNOSIS

The early diagnosis of deep venous thrombosis can be made in most patients by frequent and careful examination of the lower extremities. In an analysis of over 500 cases of deep venous thrombosis at the Massachusetts General Hospital, swelling of the leg and local tenderness over the deep veins was found in about 66 per cent. In 41 per cent, discomfort in the calf or popliteal region on forceful dorsiflexion of the foot (a sign described by Homans) was found to be present. Another useful sign was the distention of the superficial veins over the lower leg and foot, as compared with the normal extremity. A concomitant rise in the temperature, pulse and respiration in a patient with a preceding normal chart when no other cause can be found is frequently evidence of a small pulmonary embolus. In some patients the first warning of deep venous thrombosis of the lower extremities is the occurrence of a nonfatal pulmonary embolus. In our series, this was found in 35 per cent. Examination of the legs in these patients was usually negative for pain, tenderness and swelling. In cases suspected of pulmonary infarction, anteroposterior and lateral roentgenograms of the chest should be taken. The sudden development of a severe pleuritic type of pain, especially if it is accompanied by hemoptysis, is almost pathognomonic of pulmonary infarction and deep venous thrombosis of the lower legs. The electrocardiogram in some cases is of aid in differentiating between pulmonary embolism and coronary thrombosis. In the young patient, because of better collateral blood supply in the lungs through the bronchial arteries, infarction is not so apt to occur so that evidence of acute cor pulmonale may aid in the diagnosis of pulmonary embolism. A visualization of the deep venous circulation of the lower extremities by phlebography has been given up as a routine procedure in our clinic because the interpretation of the phlebograms is frequently equivocal, especially in the veins of the lower legs. One of our patients with bilateral negative phlebograms died 48 hours later of a massive pulmonary embolus.

PREVENTION

Deep venous thrombosis cannot be prevented in all postoperative patients, but its incidence can be greatly reduced. Every effort should be made to encourage the venous return from the lower extremities. In patients who must remain in bed, bicycle exercises (active or pas-

sive) are of definite benefit. Another important factor is the position of the patient. The best arrangement is to elevate the head of the bed with blocks under the bed posts so that the patient is lying on a slight incline. A board is placed at the foot of the bed, so that the patient can push against it with his feet as he will tend to slide down in the bed. This automatically will result in exercise and contraction of the calf muscles, thus favoring the emptying of the veins in the areas where thrombosis generally originates. Abdominal distention, if it occurs, should be corrected, because it increases intra-abdominal tension and interferes with venous return from the lower extremities. Tight abdominal binders should be abolished for the same reason. Early ambulation, even after major abdominal surgical operations, is another important prophylactic measure. Abdominal incisions should be made and sutured so that the patient may get out of bed on the first or second postoperative day. If he is allowed out of bed soon after the operation, it is extremely important that he should be made to walk and not allowed to sit in a chair for at least a week. In the sitting position there is a tendency to venous stagnation with resulting thrombosis. While early ambulation is often advantageous, it will not prevent venous thrombosis and pulmonary embolism in all cases, so that examination of the extremities should still be carried out at frequent intervals. The anti-coagulants, heparin and dicumarol, should be used chiefly for the prophylaxis of thrombo-embolic disease. Heparin is the more difficult to administer, but its effect can be more readily controlled. If it is used, frequent clotting times should be taken. Dicumarol, on the other hand, is readily administered by mouth, but adequate laboratory facilities to carry out frequent prothrombin time determinations are absolutely necessary if it is used. The effect of the drug is not obtained until 24 to 48 hours after its administration. Severe, and in some instances uncontrollable, hemorrhage has been reported following use of this drug, so that it must be carefully controlled.

The bilateral interruption of the superficial femoral veins is another prophylactic measure which we have used for the past year in patients who are most likely to develop venous thrombosis and pulmonary embolism. In my own patients it is carried out on every individual 50 years of age or older who is subjected to a major abdominal or pelvic operation for malignancy, since in our clinic, the highest incidence of thrombo-embolic disease occurs in this group. The venous interruption should be of the superficial femoral vein at its junction with the deep femoral vein. It is important that the proximal ligature be placed so that there is no blind end of superficial femoral vein between it and the deep femoral vein in which a thrombus might originate and propagate upward into the common femoral and iliac veins. In a group of over 200 patients who have had this procedure properly performed, no case of fatal pulmonary embolism has occurred and only in a rare instance has there been any evidence of deep venous thrombosis, despite the fact that all the patients are in the group in which one would expect a high incidence of thrombo-embolic disease.

TREATMENT

The conservative treatment of an established case of deep venous thrombosis with rest in bed, elevation of the extremity and the application of hot or cold packs should no longer be acceptable except in the unusual case, because it does not protect the patient from fatal pulmonary embolism. Injection of the lumbar ganglia with procaine solution frequently gives symptomatic relief and tends to shorten the period of hospitalization, but it does *not* eliminate the danger of pulmonary embolism. The anticoagulants, heparin and dicumarol, have also been used but in our hands not infrequently after they have been discontinued both minor and fatal pulmonary emboli have occurred.

The more radical treatment by means of bilateral femoral vein interruption greatly shortens the course of the disease and in practically every case will prevent fatal pulmonary embolism. This method was first described by Homans in 1934. The first case in our hospital was treated by this method in 1937. Since then, we have interrupted one or both femoral

veins in more than a thousand patients. It is a simple and safe procedure that can be carried out on very ill patients without any serious detrimental effects to the extremity. The anesthesia of choice is local infiltration with one per cent procaine solution.

Bilateral femoral vein interruption should be carried out on (1) patients who have developed a nonfatal pulmonary embolism, whether or not there are signs of venous thrombosis in the legs, (2) on any patient who develops venous thrombosis in the deep veins of the lower extremity as evidenced by tenderness, pain, swelling, dilated superficial veins or discomfort in the calf when the foot is passively dorsiflexed, (3) on postoperative or medical patients who develop a concomitant rise in temperature, pulse and respiration, who have had a previously normal chart and in whom the elevation cannot be explained by some other cause, (4) if venous thrombosis is diagnosed in one extremity, the femoral vein of the other leg should be interrupted in all cases, even though no signs of venous thrombosis are detected, and (5) prophylactic bilateral femoral vein interruption is a justifiable procedure in patients over 50 years of age, who are subjected to major abdominal or pelvic operations for malignant disease. This may be performed as a separate procedure, or simultaneously with the primary surgical operation. Prophylactic interruptions are also indicated in elderly patients who are subjected to open reduction of intertrochanteric fractures of the femur, since in this group, there is a high incidence of fatal pulmonary embolism.

The purpose of the operation is to interrupt the long column of blood in the femoral and popliteal veins, so that if a clot forms there, it cannot be swept upward to lodge in the pulmonary artery. In most patients, the operation should be carried out before the femoral vein has become thrombosed. In such cases, interruption of the superficial femoral vein just distal to the deep femoral is recommended. The operation can be more readily and safely performed by the average surgeon, because of the absence of any tributaries of the femoral vein at this level. If a thrombus is found occluding the femoral vein it is considered better to interrupt the common femoral vein proximal to the junction of the superficial and deep femoral veins. This will prevent embolism from the deep femoral branch. The vein may be tied in continuity, but it is better to divide it and ligate each end with a primary ligature and a secondary stitch ligature distal to it in each stump. These ligatures should be of the non-absorbable type, either cotton or silk.

RESULTS

Minor pulmonary emboli have occurred in about five per cent of our cases following femoral vein interruption. The majority of these arise from the deep femoral branch. Only two deaths from pulmonary embolism have occurred following bilateral femoral vein interruption in our series of over 1000 patients. The superficial femoral veins had been interrupted in one and the common femorals in the other. Neither patient died of a sudden massive embolus, but succumbed rather to the cumulative effect of relatively small emboli arising from clots in the iliac veins. Both were elderly patients suffering from severe incurable debilitating diseases. The common femoral vein should not be interrupted above the saphenofemoral junction. This is especially true in the elderly patients, since they may have a poor venous collateral circulation. If at operation, both the common femoral and the saphenous veins are found to be thrombosed, the interruption still should be done below the saphenofemoral junction, otherwise a permanently swollen extremity may result. We recommend that a vertical type of incision be used to expose the vessels, since this gives more adequate exposure and if a large vessel is accidentally injured causing severe hemorrhage, it can be more readily controlled through a longitudinal incision. An additional reason is that fewer lymphatics will be divided than if a transverse incision is made.

No serious untoward sequelae have resulted from the operation. In one series of 367 cases, there were only five instances of wound infection. Hemorrhage from the slipping of a ligature occurred in three cases. This will not

occur if a stitch ligature is used distal to the original tie. Lymphorrhea occurred in 15 cases. This condition is self limited, since the lymph drainage soon ceases and in no case has it persisted longer than two weeks. This complication can be reduced to a minimum by adhering to our type of incision. In a few cases, lymph vessels will be visualized and if they are torn or severed they should be ligated. Closure of the wound should be meticulous and done in layers to obliterate as many dead spaces as possible.

The morbidity of thrombo-embolic disease following femoral vein interruption has proved to be gratifyingly short. The average number of days from bilateral femoral vein interruption to a normal chart was 5.3, which is a great reduction over the conservative method of rest in bed, where the time was usually three to four weeks. Patients, whom it was not necesssary to hospitalize for other conditions, were discharged from the hospital on an average of 8.9 days following femoral vein interruption, which is also a great reduction from the old methods which required four to six weeks.

PROCEDURE

The operation of femoral vein interruption is carried out as follows: The patient's trunk is slightly elevated to insure positive venous pressure at the level of the femoral veins so that if a thrombus is found in the vessel it will tend to be forced out through the opening made in it rather than be aspirated to the heart. One per cent procaine infiltration anesthesia is used almost routinely.

The incision is a vertical one and parallels the course of the femoral artery which is readily palpable in the groin. It extends about an inch above the crease in the groin if the common femoral vein is to be interrupted, but if the superficial femoral vein is to be interrupted the upper end need extend only to the crease. The length of the incision is approximately three to four inches. The saphenous vein is carefully preserved and not traumatized; it is retracted medialward and the femoral lymph nodes lateralward, exposing the fascia lata of Scarpa's triangle. This is incised exposing the femoral sheath, which is opened longitudinally bringing into view the femoral artery and vein. The artery is carefully separated from the vein and retracted lateralward. It is preferable not to isolate it completely with a ligature around it, since this may traumatize it resulting in thrombosis and gangrene of the extremity. Retraction by grasping the adventia with smooth forceps will suffice.

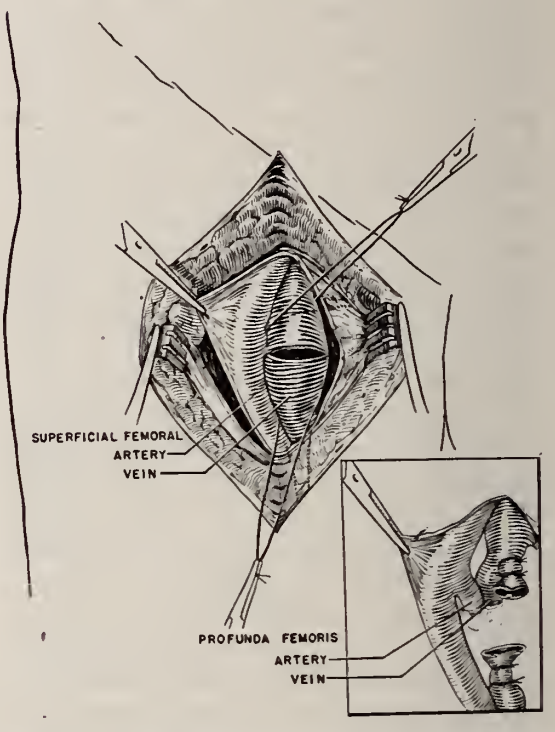


Figure 1. Interruption of the superficial femoral vein. This artist's drawing shows the exposure of the right superficial femoral vein using a vertical incision, the upper end commencing at the groin crease. The dilatation of the vein localizes the junction of the superficial and deep femoral veins. The femoral artery is retracted lateralward. The incision in the vein is indicated and should always be transverse. The inset shows the divided superficial femoral vein with both ends doubly ligated. The ligatures on the proximal end should be placed as close to the deep femoral vein as possible so that a blind segment of vein is not formed in which a secondary thrombus may develop and from which a pulmonary embolus might occur.

(Courtesy Mason, Robert L., and Zintel, H. A.: Preoperative and Postoperative Treatment. By permission of W. B. Saunders Company, publishers, Philadelphia.)

Two ligatures are passed around the femoral vein before opening it, since with these, hemor-

rhage can readily be controlled after removing a thrombus. The incision in the vein should always be transverse through about a third of its circumference. This permits the more ready application of the final ligatures. If a thrombus is encountered, it is withdrawn by aspiration through a glass cannula. The upper segment is always aspirated first. Every attempt is made to clear the proximal segment so that free bleeding is obtained from above, indicating complete removal of all the thrombi. The introduction of the glass cannula proximally has never dislodged a thrombus in our experience. After aspirating the proximal segment, the distal segment is similarly treated.

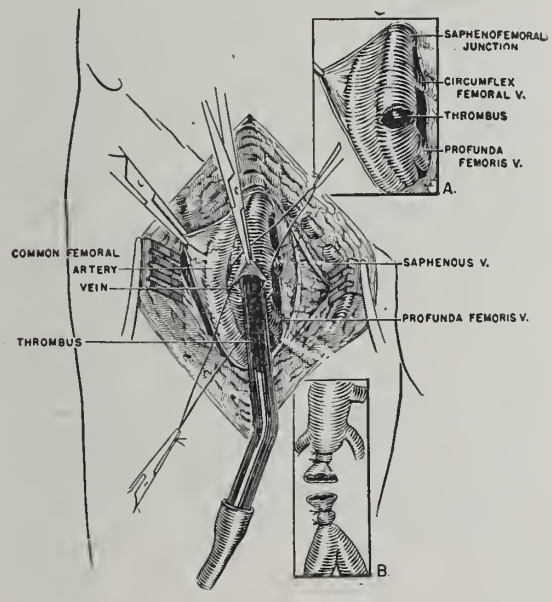


Figure 2. Interruption of the common femoral vein with thrombectomy. An artist's drawing to show the exposure of the right common femoral vein, the upper end of the incision should be two centimeters above the groin crease. The femoral artery is retracted lateralward. Two untied ligatures have been placed around the vein to control the bleeding after thrombectomy. The thrombus is removed by aspiration through a glass cannula. The proximal segment is always aspirated first. Inset A. shows the thrombus protruding through the transverse incision in the vein. Inset B. shows the completely divided vein with both ends doubly ligated with non-absorbable ligatures. The division is above the junction of the superficial and deep femoral veins.

(Courtesy Mason, Robert L., and Zintel, H. A.: Preoperative and Postoperative Treatment. By permission of W. B. Saunders Company, publishers, Philadelphia.)

This is not so important but it is felt that it aids in the reduction of the edema since more collateral venous channels are re-opened. The previously placed ligatures are then tied and the vein divided. Secondary transfixing sutures are placed distal to the original ligatures in the cuff of both ends of the vein. Cotton or silk ligatures are used routinely. The interruption of the superficial femoral vein should be as close to the deep femoral vein as possible. The latter vessel should always be visualized if this site of interruption is chosen. A bulbous dilatation of the superficial femoral vein at its junction with the deep femoral vein is a constant anatomic landmark which localizes the junction of these two vessels. If the common femoral vein is interrupted, care should be

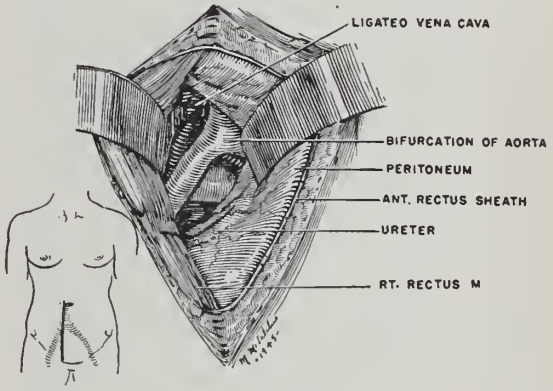


Figure 3. Interruption of the inferior vena cava. An artist's drawing to show the extraperitoneal exposure and ligation in continuity of the inferior vena cava using a right paramedian incision. The rectus muscle is retracted lateralward and the ureter, peritoneum and its contents medialward. The incision extends from the pubis to about five centimeters above the umbilicus. For ligation, we use two non-absorable ligatures of silk or cotton.

(Courtesy Mason, Robert L., and Zintel, H. A.: Preoperative and Postoperative Treatment. By permission of W. B. Saunders Company, publishers, Philadelphia.)

taken not to tear the muscular branches which are always found arising from this vein. In some instances they will be so close together that it will be impossible to ligate and divide the vessel without separately ligating and dividing a few of these branches. Ligation in continuity in a few cases may be necessary but ligation and division is considered the preferable procedure. The wound is irrigated with iso-

tonic solution of sodium chloride and closed meticulously in layers without drainage.

Interruption of the venous system at a higher level, such as at the inferior vena cava or common iliac vein, may be necessary in certain cases. These high levels of interruption should be reserved for the unusual case of thrombo-embolic disease, in which the femoral veins have been thrombosed for a week or more and pulmonary emboli are still occurring, or for cases of septic pulmonary embolism secondary to a septic process in the pelvis. Inferior vena cava interruption seems preferable to bilateral common iliac vein interruption because the venous systems from both extremities can be interrupted through a single exposure. The extraperitoneal approach is recommended. This may be either through a flank incision or preferably through a right paramedian incision retracting the rectus muscle lateralward and the ureter, peritoneum and its contents medialward from the iliac fossa. Interruption of the inferior vena cava has always been carried out in continuity, since it is difficult to mobilize sufficient of this large vessel to ligate and divide it safely. This is a major surgical procedure, requiring general or spinal anesthesia in contradistinction to femoral vein interruption. The development of postphlebitic lower leg ulcerations and varices of the abdominal wall following its interruption, are additional factors that have lead us to use it only in the unusual case of thrombo-embolic disease. In a group of 14 caval interruptions in our clinic, two patients developed indolent ulcers of the lower leg and a third has had bilateral recurrence of them, whereas only one transient postphlebitic ulcer has occurred in the group of over a thousand patients with femoral vein interruption.

CONCLUSIONS

1. Bilateral femoral vein interruption is a safe and effective procedure to prevent fatal pulmonary embolism.

2. This operation should be performed as definitive treatment on any patient who develops deep venous thrombosis in one or both lower extremities or who has had a non-fatal pulmonary embolus whether or not signs of venous thrombosis are detectable in the legs.

3. Prophylactic bilateral femoral vein interruption has been an effective measure in our hands to prevent fatal pulmonary embolism in patients who are likely to develop post-operative thrombo-embolic disease.

4. Interruption of the inferior vena cava distal to the renal veins is a safe procedure which should be used in cases of long standing thrombosis of the femoral and iliac veins with pulmonary embolism and in cases of septic pulmonary embolism secondary to a septic thrombophlebitis in the pelvis.

1101 Beacon Street

VA AND THE ADVANCEMENT OF MEDICAL KNOWLEDGE

All physicians of the state are invited to hear a talk by Dr. Arden Freer, Executive Officer, Department of Medicine and Surgery, Veterans Administration (Washington, D.C.) to be held Friday evening, October 31, at the Academy of Medicine, 8:30 p. m. The Academy is at 91 Lincoln Park, Newark. This meeting is under auspices of the Clinical Society of the Veterans Administration of New Jersey.

OLD AGE AND DISEASE

A definitive review of the relationships between old age and disease is scheduled for Friday evening, December 19, 1947. Speaker of the evening will be Dr. John Murray Steele, Director of Research, New York University. The lecture will begin at 8:30 p. m. in the auditorium of the Beth Israel Hospital, 201 Lyons Avenue, Newark, and is held under sponsorship of the Clinical Society of the Veterans Administration of New Jersey. All physicians are welcome to attend this meeting and participate in the discussion of this interesting subject.

SIMULATED MENTAL RETARDATION PRODUCED BY EMOTIONAL NEGLECT

Ralph Neil Shapiro, M.D., Newark, N. J.

Physicians are frequently misled into making a diagnosis of mental retardation when the clinical picture is actually produced by emotional neglect. More than one such child has been scheduled for pneumo-encephalogram, spinal tap, electro-encephalogram, cisterna puncture, elaborate psychometric studies and other procedures because the clinical picture so vividly mimicked mental retardation. It therefore behooves every general practitioner, pediatrician and other doctor who has contact with children to weigh seriously the factor of emotional neglect before concluding that the child is retarded.

In a typical case a child of normal intelligence has lived most of his brief life in an institution or in some other physically satisfactory but emotionally inadequate environment. This child has been fed scientifically, housed well, bathed, diapered, kept warm and protected from harm and infection. The doctor would expect this child (who, let it be remembered has normal intelligence) to develop according to the accepted norms for crawling, sitting, walking, talking and responding to other human beings. However, by the end of the first year, certain unusual features of his behavior became conspicuous. Examined at that time, he is likely to present the following picture:

He is dull, apathetic and unresponsive. When spoken to, he stares ahead, looks down silently, or begins to cry. When offered toys there is no attempt to grasp them; indeed there is no evidence that the child has even noticed them. Motor habits are retarded with a failure to sit up or stand or even to use the hands or arms properly. Behavior remains on an early infantile level with motor activities of senseless patterns, some of a highly compulsive type. There is a complete lack of interest in the surroundings. Soiling and wetting occur long after we expect that habit training would have been established. Feeding difficulties are frequent and accompanied by a lack of interest in food. Attempts at training with feeding implements other than a bottle are met with failure. Regurgitation and occasionally rumination are practised.

Physical examination including survey of the eye grounds and a thorough neurologic study is essentially negative. Usually, however, due to refusal to eat, these children are underweight.

Observing this picture, the doctor naturally concludes that he is dealing with a case of mental deficiency, cerebral spasticity or general developmental retardation. The conclusion is a natural one since objectively the child presents the exact picture of the retarded infant. However, during the past year, I have found this clinical syndrome in five infants whose subsequent development was accelerated after the introduction of an emotionally richer environment. With one exception these children had been sent to the hospital from charitable institutions by attendants who observed the picture above described.

After considering electro-encephalogram, pneumo-encephalogram and spinal punctures, the staff decided to assign nurses who were especially interested in this problem, to act as "mother substitutes". The one exception was a four month old infant who had been waiting since birth for a much needed plastic reconstruction of a cleft palate and had never left the hospital since birth. He was in a busy pediatric ward, getting little attention other than routine physical care. This infant seemed unusually unresponsive to the nurses and on examination, I found that the child was unable to hold his head erect and was unusually apathetic and unresponsive. Repeated examinations were made with similar results. Instructions were issued to a nurse regarding fondling, playing and feeding.

For the other, and older infants, one "mother substitute" nurse was assigned to each infant. These nurses talked to the children, fondled them, presented them with a wide variety of

toys. This was done with the realization that it would not be an adequate substitute for family life. I hoped, however, that improvement would be such that it might be possible later on to enrich the emotional climate by placement in a foster home. I examined each patient two months later and found marked improvement. The infants were more robust, more active, had greater sparkle, and showed acceleration in motor, adaptive and language behavior. This observation seemed to establish the fact that the children had no genetic inadequacy or organic deficiency. Plans were made for proper placement. Even when this is accomplished, these children may continue to display evidences of some personality defect. Education, affection and psychotherapy will modify these defects, though perhaps never completely correct them; and for a long time we may expect the unpatterned and unorganized behavior recognized as characteristic of the "unmatured, infantile" type.

Emotionally deprived children who are not placed in a more "affection-giving" environment by the second year, may show extreme aggressiveness and destructiveness. We may expect rages and temper tantrums alternating with periods of shyness and withdrawal. Occasionally speech may be unintelligible, and habit training lags. Motor development may be immature. Intelligence testing is useless due to a lack of cooperation.

Ribble, Bender, Levy, Lowrey, Goldfarb and Spitz have all made extensive observations of children deprived of "mother love" or otherwise suffering from unrequited hunger for affection. These workers have found such children to be depressed to such an extent that they reject everyone around them.

Next to survival itself, the human being requires and hungers for human response. Lacking such response, the human being retrogresses. In children, love relationships have a dynamic effect on the body activities and help to stimuate mental growth. Not only affection, but interaction with others helps to give security to the child. Anna Freud found that British children surrounded by their loved ones were better able to withstand bombings than those separated from the family. Natives of Okinawa were able to "take" bombings much more calmly than the Japanese and other races. This was presumably due to the particularly close family life the Okinawan enjoyed.

A baby's helplessness makes him utterly dependent upon his mother and out of this grows that interchange of affection that gives the child his security and psychologic equilibrium. This is a dynamic force for healthy personality integration and organic vitality. The child's emotional life requires reciprocity with another human, a mother, or "mother substitute". It needs a partner. The receipt of affectionate attention actually stimulates all the sensory areas and organs thereby increasing responsiveness, alertness and the capacity for experiencing. One might say that lacking this stimulation, the infant becomes "shocked" and stuporous. There have been instances of children hospitalized for ailments which, under ordinary circumstances, would have been easily cured, who failed to respond because of the "shock" caused by the separation from the mother. One New York hospital actually hired matronly looking women to visit the hospital for fondling purposes.

Maturation involves physical, emotional and mental growth, according to a plan and sequence. Since these three are interdependent, it should be obvious that physical and mental growth can be impaired by a lack of emotional interchange. The normal infant has an innate capacity which is realized only if his psychologic needs are satisfied. Without this, he fails to exercise his developing skills and lacks self expression. The mechanism of maturation is rooted in this sequence: (1) there is an increase of ability to receive impulses through the sense organs, (2) the brain grows in ability to receive and interpret and associate, (3) the infant increases power to respond purposefully and selectively.

Among infants, the only way of measuring mental development is to match the child's physical accomplishments against an established norm. Since victims of emotional neglect show an appreciable impairment of "physi-

cal" maturing, the examiner decides that the infant is "retarded".

One conclusion seems inescapable. Mere physical care of infants by hired attendants in institutions actually leads to personality distortion and retardation of growth and development. This strongly suggests the need for changes in previously accepted methods of institutional care. Specifically, it would appear that the following procedural changes are indicated.

Attendants should be selected for their particular attachment to infants and for their joy in the experience of handling them. To provide the child with continuous interchange in relationship, one attendant would be assigned to the same infant for all handling. It has even been suggested that "family groups" within the institution be established. This might be impractical, but the value of this arrangement would be inestimable. Foster home care with a family setting is much more desirable.

Much more could be accomplished in this direction in hospitals caring for sick children. If an infant appears retarded there is a tendency to plunge into difficult, hazardous or painful neurologic procedures. Before submitting the patient to this, the social and emotional atmosphere should be evaluated. If there is any possibility that the retardation is not due to gross structural brain disease, the doctor should institute a trial period under conditions providing for an emotionally rich and affection-giving atmosphere—preferably with a single attendant. Nothing is lost by such a trial period. If the retardation is due to emotional deprivation, the change may cause a blossoming of the infant's development that, when it occurs, is one of the most rewarding and heart-warming experiences of medical practice.

668 Clinton Avenue

PERSONALITY AND SOCIAL ASPECTS OF DISABILITIES

An unusual scientific program of interest to all physicians concerned with emotional and social problems or with problems in rehabilitation generally, is scheduled for Friday evening November 28, 1947, at the Academy of Medicine, 91 Lincoln Park, Newark. Essayist of the evening will be Dr. Luther E. Woodward, Field Consultant to the National Committee for Mental Hygiene. The meeting is under the auspices of the Clinical Society of the Veterans Administration of New Jersey. Meeting opens 8:30 p. m. Dr. Woodward's subject will be: "Personality Aspects of Disabilities".

FELLOWSHIP IN INTERNAL MEDICINE

Fellowships at an annual stipend of $2200 to $3000 will be available after June 1948, to physicians who are seeking a career in internal medicine. Application blanks and further details are available from American College of Physicians, 4202 Pine Street, Philadelphia 4.

TONSILAR REMNANTS

Complete removal of infected tonsil remnants is essential for patients with focal infection, especially chronic phlebitis and arthritis. Otto Meyer notes that infection spreads from the tonsil tissue, enters the endothelium of the jugular veins by way of small connecting veins, and causes jugular phlebitis and polyphlebitis in peripheral veins. Proliferative endophlebitis interferes with venous drainage of a joint and seems to be the most important factor in the causation of arthritis.

Tonsilectomy fails to remove the infected tonsil completely in 73% of cases. The remaining remnants of tissue are of greater menace than the original tonsils. Tonsil stumps harbor more pathogenic bacteria than tonsils removed for the first time.

Infected tonsil stumps may be diagnosed by external palpation of the tonsilar fossae. The physician stands behind the seated patient and palpates the outer angle of the tonsil bed which is situated behind and below the submaxillary angle. Induration and sensitiveness to pressure in this area indicate infected stumps.—Eye, Ear, Nose and Throat Monthly.—25:244.

ERYTHEMA MULTIFORME AS A SEQUELA OF DERMATITIS VENANATA

C. C. Carpenter, M.D., Summit and Morristown, N. J.

Erythema multiforme is reported most frequently in association with active tuberculosis. However, as this paper will show, it may be produced by a variety of other causes.

SYMPTOMS

Skin manifestations of erythema multiforme [1] may occur in two distinct forms: (1) The so-called "Hebra type" characterized by discoid lesions first appearing on the hands and feet with typical concentric target-like rings; and (2) a "polymorphous erythema" with pink to reddish papules found predominantly in the same locations. In both types macular, papular, vesicular and bullous lesions may be scattered diffusely over the body, and there may be involvement of mucous membranes. In most instances the generalized symptomatology is mild but may include fever, articular pains, cough, malaise, and vomiting. Usually a leucocytosis of above 10,000 is present with an increase in the neutrophils.[2] Average duration of the disease is about thirty days, with generalized symptoms subsiding within the first two weeks.

ETIOLOGY

In addition to such well known causes for this syndrome as seasonal influences, ingestion of stale foods, and anaphylaxsis [3] to drugs and foods, occasional epidemic outbreaks have been reported.[4]

Ramel [5] blames the dissemination of toxic products from a tuberculous focus, or the effect of "biotropic influences" on such a focus through the action of infectious, biologic, or chemical agents. Erythema multiforme has also been noted in association with other chronic diseases such as tinea profunda,[5] syphilis,[17] and leprosy.[6] Recently many reports have appeared incriminating both acute bacterial and virus diseases. Constantino [7] believed he demonstrated a streptococcus as the etiologic agent, and Hruszek [8] suspected the same organism due to his patients' satisfactory response to prontosil. In addition, streptococci were recovered twice as frequently as staphylococci, from suspected foci by Noojin and Calloway.[2] Duemling,[9] and Nishiyama [10] both believe that foci of infection are among its principle causes.

In favor of a virus etiology of this disease are the cases reported by Proppe [11] where it followed herpes labialis, aphthous stomatitis, and extensive sunburns. His views are supported by Forman and Whitewell,[12] and Anderson [13] who found, in addition, that multiple small-pox vaccinations were of benefit in preventing recurrences in some forms associated with herpes simplex. Sulzberger and Asher [14] observed erythema multiforme following injections of yellow-fever virus vaccine, but suggested this was probably an allergic mechanism, rather than a direct infectious or virus effect.

Many medications have been known to provoke attacks of this syndrome. Bruce-Jones [15] reported an outbreak following minute doses of casinogen in a patient known to be sensitive to milk. A "biotropic influence" was blamed by Milian [16] when this eruption appeared nine days following the ingestion of a colloidal iodine preparation, and also following an injection of neoarsphenamine [17] for an ulcerous vaccinal syphilitic lesion. Ritchie and Weldon [18] reported a fatal hemorrhagic and bullous form of erythema multiforme appearing nine days after large dosages of dilantin sodium. Until more exact criteria are established it is difficult to determine whether a drug allergy, biotropic influence,[19] or a Herzheimer-like effect[20] is responsible for appearance of this disease during the administration of sulfonamides [21, 22, 23] and penicillin.[24]

Only two previous reports could be found in which erythema multiforme was noted following contact dermatitis. In one patient [25] this occured after a severe irritation following the combined use of a proprietary hair tonic and tincture of larkspur for pediculosis capitis; the other case resulted from a lacquer dermatitis [26] produced by sand-papering a Japanese souvenir rifle. Because of the infrequent association of these two diseases, it was believed that further reports would be of interest.

CASE ONE

This was a white male, aged 30, who had been engaged in the manufacture of cholestrol for six weeks. He denied previous contact eruptions or allergies. For ten days, he had had a diffuse oozing and pustular crusted superficial dermatitis involving the forearms and cubital fossa, which had been further aggravated by "house painting" and the use of a proprietary ointment. A week following the height of the localized dermatitis, a spreading generalized eruption appeared and covered the body within twenty-four hours. This consisted of macules, papules, vesicles and pustules with involvement of the dorsa of the hands and feet. A few erythematous macules were present on the buccal mucosa.

On admission to the hospital his temperature was 100°, and the white blood count 16,900 with a differential of neutrophils 60 per cent, lymphocytes 20 per cent, eosinophils 14 per cent, monocytes 6 per cent and band cells 10 per cent. Urinalysis was normal. His temperature became normal after the fifth day following soothing local therapy and hexamine by mouth. As the eruption subsided, a secondary furunculosis developed which did not subside for another two weeks. Prior to discharge he was patch tested to the "mother liquor" of the cholestrol, that had been the original source of irritation and was found severely sensitive.

CASE TWO

A white housewife, 45 years of age, developed a weeping erythematous eruption of the face, neck, chest, and upper back in the area on which she had applied a sun-tan lotion the previous day. These had been treated with starch and soda compresses and calamine lotion. Within two days, she had a temperature of 101°, and nausea, which was followed by a symmetrical macular eruption on the backs of the hands, dorsa of the feet, abdomen and lower back. White blood count at this time was 12,200 and the differential count showed neutrophils 69 per cent, lymphocytes 23 per cent, and eosinophils 8 per cent. Rapid improvement followed the administration of acetylsalicylic acid, but the eruption did not completely subside for a month.

CASE THREE

A white female college student, 19 years old, developed oozing erythematous pustular crusted patches in both axilla following the application of a deodorant. No other contact irritant could be elicited from the history, although a patch test to the deodorant was negative. With local soothing therapy, an improvement in the original eruption was noted. Elixir benadryl had also been used to control the itching. Four days later a pin-point vesicular eruption was noted on the hands and arms, with a faint macular eruption on the body. The white blood count at this time was 10,250 with a differential count of neutrophils 80 per cent, lymphocytes 16 per cent, eosinophils 3 per cent and basophils 1 per cent. Within the next seven days the hands and lips became edematous and the vesicles had enlarged to small bullae. A distinct maculopapular eruption covered the body, thighs and legs, and small vesicles were present on the lips. Evening temperature averaged 99.5° and the white blood count had increased to 13,900. Slight recrudescences of the eruption were noted long after the elixir benadryl had been discontinued, but the patient was discharged just a month after erythema multiforme had appeared. At the time of discharge the white blood count was 8,450 with a normal differential count.

CASE FOUR

A 36 year old white male had recently been working in a refrigerator plant, but had no trouble until three days after he had been in the woods to cut down a Christmas tree. At that time he noticed an oozing and crusted eruption of the hands and forearms that also showed the characteristic linear vesicular streaks so typical of dermatitis venanata. There was a blotchy erythematous eruption of the face and neck. Patch tests to the tree as well as the oils used in his work were negative. His past history revealed several recurrences of a vesicular eruption of his hands.

For the first week of therapy a gradual improvement was noted in the involved areas. Then suddenly there appeared a papulovesicular eruption spreading first on the upper arms and then on the body, thighs, legs and dorsum of the feet. Vesicles and bullae also appeared on the hands. There was no fever or malaise although the urine showed some granular casts

and the white blood count was 14,600 with a differential count of neutrophils 82 per cent, lymphocytes 15 per cent, and eosinophils 3 per cent.

The eruption slowly subsided with the use of acetylsalicylic acid, pyribenzamine, and gradually increasing dosages of penicillin. He was not considered well enough to discharge until seven weeks after the eruption had started, and at this time his white blood count was 6,200 with a normal differential.

COMMENT

In the cases reported, an erythema multiforme followed by two to ten days the appearance of a contact dermatitis that showed visual evidence of surface contamination by bacteria. In only case three could the possibility of a drug allergy be considered, and even this seemed unlikely as the patient had never taken this medication before, and the usual five to nine day latent period necessary to develop a drug allergy had not elapsed before erythema multiforme appeared. The possibility of cutaneous autosensitization through the action of staphylococcus toxin on the keratin of the skin, as suggested by Hopkins,[27] might be considered, but it has never been reported as a cause of erythema multiforme. It seems most probable that these sequelae were produced by the absorption of bacteria, viruses or their products from the superficially infected areas of the dermatitis venanata.

SUMMARY

1. The newer concepts of the etiology of erythema multiforme are reviewed showing its relationship to drugs, bacteria, and viruses.

2. Four patients are reported with secondarily contaminated dermatitis venanata, which was followed in two to ten days by typical explosive attacks of erythema multiforme.

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129 Summit Avenue
181 South Street

PENICILLIN IN GONORRHEA

The present report describes the preparation of water-in-oil emulsions of penicillin as follows: 100,000 O.u. to 200,000 O.u. of penicillin are dissolved in 1.4 cc. of sterile 0.85 per cent saline, in the rubber-stoppered vial in which it is packaged commercially. To this is added, by means of a 5 or 10 cc. Luer syringe and 17-gage needle, 3.1 cc. of an autoclaved mixture of peanut oil (20 parts) and "Falba" (11 parts). Emulsification is accomplished by repeated withdrawals and ejections of the penicillin-oil-Falba mixture from the syringe into the vial containing the original penicillin.

A table is presented giving the results of penicillin therapy in 557 patients with gonococcic infections, using various treatment schedules. It was found, for instance, that single injections of 150,000 units of penicillin in water-in-oil emulsion cured 101 of 105 patients, a cure rate of 96.2 per cent, whereas a simultaneous injection of 100,000 units of penicillin in water-in-oil emulsion and 50,000 units in aqueous solution cured all of 49 patients, a cure rate of 100 per cent. No untoward local or systemic reactions were noted.—Cohn et al., Journ. Ven. Dis Inf. 27:154.

EXAMINATION OF THE STERILE COUPLE

Daniel B. Roth, M.D., Teaneck, N. J.

There are, in this country, three million couples who are involuntarily sterile. Since about ten per cent of all marriages are barren, this is a problem of the first magnitude. Too many physicians, who would consider it unthinkable to dismiss a woman with a suspicious nodule in her breast without a biopsy, will still dismiss an infertile couple after a pelvic examination and scrutiny of a drop of semen under the microscope. After these incomplete examinations, patients are subjected to a long series of fruitless injections and "treatments" and either become discouraged or go from doctor to doctor until they come under the care of someone who is able to do more complete studies. Much time is lost in this way and many babies remain unborn. Through better and more intelligent investigation, many more of these couples can be helped.

Fertility is the summation of the fertilization ability of *both* partners. Of infertile marriages about 25 per cent are due to exclusively female factors and about 25 per cent to exclusively male factors. In the remaining 50 per cent, the cause lies in a lowered fertility on both sides. Among this group, union with other partners of higher fertility frequently produces children.

In order for pregnancy to occur four essentials must be present: (1) a sufficient number of sperms must be deposited and must enter the cervix; (2) the woman must have normally patent tubes; (3) coitus must take place at or near the time of ovulation; (4) after fertilization there must be a normal endometrium prepared for implantation. The examination which does not determine all these factors is incomplete.

A complete history of both husband and wife should be obtained with special reference to severe constitutional illnesses, general infections (such as mumps and malaria), genital infections, exposure to radiation, operations, previous pregnancies and the onset and character of puberty. Of special importance is a history of acute appendicitis especially with peritonitis or a history of salpingitis or postabortal or postpartum infection. The coital history should be reviewed especially in regard to its frequency and its relation to the ovarian cycle. From the wife, this information should be elicited about the menses: regularity, length, amount, character and whether there is intermenstrual bleeding or pain. From the husband, we should learn if there are any aberrations of the ejaculate, such as bleeding; and whether ejaculation is normal or premature.

After this, a general physical examination is given to both partners, with special reference to secondary sex characteristics and to signs of genital anomalies, infections or abnormalities. Routine laboratory work includes complete blood count, serology, Rh determination, sedimentation rate, urinalysis and basal metabolism.

Special attention is paid to examination of the cervix. Its position should be noted, since an abnormal position may prevent proper deposition of the semen in the os. The patulousness of the os and the presence of discharge are of prime importance. A tight os, filled with thick purulent mucus may be an effective bar to the passage of spermatozoa. Elimination of the infection frequently alleviates the sterility.

After completion of the preliminary survey a semen examination should be done. The specimen is best obtained by coitus interruptus or by manual manipulation. It should be collected in a clean, wide mouthed bottle after a period of abstinence of three days or more. Condom specimens frequently contain inhibitors and may lead to false impressions. The specimen should be kept at room temperature. Warming the semen may inhibit its motility. Care should be taken in obtaining the specimen to see that the first few drops of the ejaculate, (which contain the majority of the spermatozoa) are not lost.

Examination of the semen includes a study of its physical characteristics, an estimate of the motility and endurance of the spermatozoa, and a study of the stained smear for abnormal

forms. A normal specimen has a volume of three to five cubic centimeters. It is turbid and liquifies rapidly on standing. The count should be above 60 million per cubic centimeter, of which at least 70 per cent should be actively motile. Not more than 20 per cent of the sperms should be abnormal in form. If the specimen meets these minimal standards, the male may be considered (at least relatively) fertile. If the specimen is below par, examination should be repeated and if the counts remain low, detailed urologic survey is indicated. While pregnancy has occurred in cases in which the sperm counts were below 60 million, these cases are very rare. It has been said that with the millions of sperms deposited in the vagina at ejaculation the wonder is that pregnancy does not ensue all the time. Recent work has thrown some light on this. Hyaluronidase is an enzyme found in the semen, which is believed to be the substance which liquefies the gel surrounding the granulosa cells and the ovum and thus permits penetration by the sperm. A concentration of about 20 million sperm are necessary about the ovum to carry enough of this enzyme to liquefy the gel. This would explain why such tremendous numbers of spermatozoa are required to cause fertilization.

If repeated counts are very low or sperms are completely absent, testicular biopsy is of value in determining whether the cause is a failure of production or a block in sperm transport.

Our efforts should next be directed to determining the occurrence and timing of ovulation. Simplest method is to evaluate basal temperatures and do an endometrial biopsy. Basal body temperatures of women vary with the phase of the menstrual cycle. The follicular phase is characterized by a low temperature and the luteal phase by a higher one. At the time of ovulation there is a slight fall followed by a rise of about half a degree. The higher level is maintained until the onset of the next menstrual cycle, when it falls to the preovulatory level. The temperature shift occurs regularly fourteen days prior to the onset of the next menstrual period without regard to the total length of the cycle. Persistence of the elevation of temperature beyond the expected time of the menses, is, in the absence of infection, prima facie evidence of conception. If the temperature stays at a level throughout the cycle, it indicates that menstruation is probably anovulatory. Failure to ovulate accounts for infertility in about 10 per cent of the women. This method is applicable to most women, though in a few cases, the curves are atypical and no conclusions can be drawn. In women in whom ovulation can be demonstrated, the timing of relations with the signs of ovulation frequently leads to conception. In those women who have "mittleschmertz", the pain is further evidence of the occurrence and timing of ovulation.

Endometrial biopsy should be done in the late luteal phase. Best results are obtained with biopsies taken on the twenty-fourth or twenty-fifth day of the cycle, for it is at this time that the corpus luteum attains maximum development. Caution must be exercised at this time to be sure that no early pregnancy exists and this is best done by interdicting relations during the fertile period. If this cannot be done the biopsy is best left for the first day of menstruation. It should be taken within eighteen hours of the onset of the flow. Specimens taken at any later time frequently are of little value. The biopsy gives us valuable information as to the completeness of the luteal phase of the cycle and the presence of such conditions as endometrial hyperplasia. The presence of a secretory endometrium is accepted as evidence of ovulation although recent studies have shown that progestin secretion may begin in the follicular phase.

The next phase in the investigation is determination of the patency of the utero-tubal system. This is done a few days after the cessation of the flow since at this time the endometrium and tubal epithelium are low. The tests should not be done in the presence of bleeding, genital inflammation, pregnancy or severe constitutional diseases. If the pelvic examination prior to the test reveals tenderness, the test is best deferred. The two common methods are insufflation with gas and hysterosalpingography. Use of gas is simpler and less painful, but hysterosalpingograms yield more in-

formation. In insufflation, carbon dioxide is passed through the tubes under manometric control. Normally patent tubes should permit the flow of gas under pressures of 80 to 120 millimeters of mercury. Confirmation of the flow is obtained by auscultation over the tubes and by the presence of shoulder pain when the patient sits up. Air or oxygen should not be used because they cause more pain and carry a greater risk for the patient. Salpingography is done by the use of contrast solutions such as lipiodal, visco-ray-opake and iodochlorol. However, these oils are irritating, and they are said to cause occlusion in partly obstructed tubes. Lipiodal, too, is poorly absorbed and may remain in the tubes as a foreign body for a long period. Despite these objections, the oils are of great value since they show the site of tubal obstruction and the presence of such features as submucous myomata, polyps and endometrial hyperplasia as well as uterine anomalies.

Obstruction in the utero-tubal passage is the commonest cause of infertility in the female. The tests have both a diagnostic and a therapeutic value. Mild degrees of tubal obstruction are frequently alleviated by the passage of gas or oil.

A post-coital test should be done at about the time of ovulation. At this time, the cervical mucus is most receptive to the penetration of spermatozoa. The test is done within a few hours of coitus (after a period of abstinence) and the specimen is examined under the microscope for motile spermatozoa in the cervical mucus. Motility of the sperms in the vaginal secretions is of no importance since the normal acidity will immobilize them in two to three hours. The presence of motile, active sperms in the cervix is evidence that the ejaculate is reaching the os satisfactorily.

The foregoing tests are the essential ones in an adequate sterility examination. Further studies may be necessary depending on their results, but no attempt is made here to detail all of them.

836 Garrison Avenue

TRIDIONE CAN CAUSE DEATH

The new drug tridione, widely acclaimed for the treatment of epilepsy, has been found to carry an unpredictable toxic reaction and the Sept. 7, 1946, issue of *The Journal of the American Medical Association* warns that the public should not be allowed to buy the drug without a prescription.

While tridione has been found effective in the epileptic patients with no apparent ill effects, two women are known to have died as a direct result of administration of the drug. Their case histories are reported in *The Journal.*

Both patients died from aplastic anemia. This often develops in persons who are poisoned with benzine or similar substances, or who have worked too long with radium or x-rays. One of the chief symptoms of the disease is deficient blood cell formation.

One patient, a 16-year-old girl who had suffered from seizures for three years, died following the use of tridione and hydantoin. The treatment was successful in controlling the attacks, but the patient gradually began to notice difficulty in breathing, palpitation, fatigue, and a throbbing in her head. The patient later suffered hemorrhages. All the measures used to prevent and treat infection, stimulate blood cell production and arrest bleeding proved of no value.

The other patient was a 23-year-old woman who had suffered seizures since she was five years old. After repeated major seizures, tridione was administered. Later she suffered from severe headaches, with vomiting, generalized weakness and fatigue. Autopsy revealed extensive hemorrhages throughout the body.

Death was due to tridione. The only drugs used by the patient for ten months prior to her death were phenobarbital and tridione, and she had taken phenobarbital constantly for 19 years without ill effect.

The destruction of the elements of her blood was delayed but abrupt. The acute onset of her illness came only after ten months, but it came suddenly. These facts strongly suggest a progressive accumulation of the drug, or of toxic fractions of it, in the body. As late as two days before her admission to the hospital she walked several blocks without distress. The process was catastrophic and uninfluenced by vigorous treatment.

HOMOLOGOUS SERUM JAUNDICE FOLLOWING THE USE OF SURPLUS DRIED PLASMA*

C. F. McGINNES, M.D., Washington, D. C.

The Committee on Blood Derivatives of the American National Red Cross believes that the possibility of disease transmission by injection of human blood and certain of its derivatives should be reemphasized. Although many diseases theoretically might be transmitted, homologous serum hepatitis or jaundice following administration of pooled plasma has become the greatest practical problem; first, because of the difficulty or impossibility of detecting infective donors; second, because of the practice of pooling many bloods to reduce the isohemagglutinin titer; and third, because of the availability of dried plasma as a result of the distribution of surplus blood derivatives by the American Red Cross.

In the *Instructions for the Use of Normal Human Dried Blood Plasma,* sent out to departments of health at the time of the initial distribution of the surplus plasma, attention was called to the possibility of virus transmission under the section headed *Adverse Reactions from the Administration of Human Plasma.* It was emphasized that jaundice might develop some months after administration, if a particular lot were contaminated with the virus of homologous serum jaundice.

The committee has reconsidered the advisability of distributing this plasma, but has felt that, in view of the lack of availability of whole blood or other relatively safe blood derivatives in many parts of the country, plasma would save many more lives than would be lost from the occasional severe case of hepatitis which might result from its use. At the same time, steps were taken to determine the risk to the patient from the use of the surplus plasma being distributed by the American Red Cross. Studies were initiated in several states. One with the New York State Department of Health has now progressed to the point where figures are available for tentative conclusions. In 649 patients followed for six months after transfusions of this plasma, 29 cases of hepatitis have been observed. There have been no symptoms indicative of hepatitis in 1,597 household contacts of these 649 patients, thus suggesting that the disease was homologous serum jaundice rather than epidemic infectious hepatitis. This figure of 4½ per cent represents the probable maximum incidence of the disease in recipients of random lots. It is lower than the 7 per cent incidence reported in the patients receiving pooled serum prepared by the Northwest London Blood Supply Depot in Great Britain.

While whole blood, fresh or frozen plasma, commercial plasma, and convalescent serum, may all transmit the same agent, the factor of pooling greatly increases the probability factor with plasma. On the other hand, there is evidence that the two most widely used products of plasma fractionation are free from this risk. In the case of *Immune Serum Globulin* (normal human serum gamma globulin) distributed by the American Red Cross for the prophylaxis of measles, follow-up studies have been made on 1900 patients. Only one case of jaundice occurred within six months of injection and, in that case, 74 other children received the same lot without any evidence of hepatitis. In the preparation of *Normal Human Serum Albumin* (Salt-poor), the heat treatment routinely used is sufficient to inactivate a strain of homologous serum hepatitis virus.

There is evidence that the disease may be transmitted from patient to patient in hospitals by the use of improperly sterilized syringes and needles.

This committee does not feel that plasma should be withdrawn from distribution. However, all physicians should be reminded of the potential risk in the administration of pooled plasma and urged to restrict its use to cases where it is clearly indicated and when safer

* Prepared by the Committee on Blood and Blood Derivatives of the American National Red Cross. The committee consists of Dr. Charles A. Janeway, chairman, Dr. Elmer L. DeGowin, Dr. Charles A. Doan, Dr. Isidor S. Ravdin, Dr. Robert F. Loeb, and Dr. Edwin J. Cohn,

This report distributed by the American National Red Cross.

agents (such as whole blood or serum albumin) are not available. Moreover, physicians who see patients with hepatitis should make a habit of inquiring about injections with blood or its derivatives during the preceding six months and of reporting such cases to the state department of health.

Patients who have been hospitalized within six months and particularly those who have received injections of human blood, plasma, or serum during that period should not serve as blood donors even though they may feel perfectly well. Potential blood donors should be rejected if there is a history of jaundice among members of their household within the past six months.

American National Red Cross

AMERICAN COLLEGE OF SURGEONS NEW N. J. FELLOWS

At the 1947 convocation, the following New Jersey physicians were accepted into Fellowship of the American College of Surgeons:

Theodore Bender	Paterson
William A. Berger	Newark
Nicholas A. Bertha	Wharton
Robert W. Buchanan	Summit
S. Calthrop Bump	Ridgewood
Victor E. Burn	Newton
E. Vernon Davis	Moorestown
Joseph P. Donnelly	Jersey City
Sherburn E. Edgerly	Englewood
Russell B. Grant	Hackensack
Guy B. Griffin	Orange
Merton L. Griswold	Plainfield
Bernard M. Halbstein	Long Branch
Morris Harris	Bloomfield
Meyer J. Kern	Newark
Charles Lipshutz	Bayonne
John J. McGuire	Newark
Hugh A. McLean	West New York
Malcolm E. McPherson	Hawthorne
Nicholas R. Musulin	Camden
Salvador D. Pentecost	Maplewood
Anthony M. Pernetti	Ridgewood
Euston S. Robertson	Arlington
Norman Rosenberg	Highland Park
Peter W. Ross	Passaic
Roy R. Schubert	Paterson
Edward F. Sciorsci	Hoboken
Jacob Warren	Paterson
Jerome M. Wolff	Plainfield
Joshua N. Zimskind	Trenton

SEMINAR ON PHYSICAL MEDICINE

The New York Polyclinic Medical School and Hospital, pioneer postgraduate medical institution of the United States, announces plans for a seminar on the progress of physical medicine, on December 1st, 2nd and 3rd.

Members of the faculty and invited guests will give talks and demonstrations on the progress in methods, clinical application, and in related fields, especially medical rehabilitation. The seminar will be conducted by Dr. Richard Kovacs, Professor of Physical Medicine, and his staff. The preliminary program can be obtained by writing to the New York Polyclinic Medical School and Hospital, 345 West 50th Street, New York 19, N. Y.

TALK ON ERYTHROBLASTOSIS

Dr. Philip Levine will lead a discussion on erythroblastosis at the next session of the N. J. Society of Clinical Pathologists, Saturday, November 8, at 3 p. m. The meeting will be at 15 West State Street, Trenton. All physicians are welcome to participate.

STATE ACTIVITIES

THE NEW JERSEY FORMULARY

By now each member of The Medical Society of New Jersey should have received the revised *Fifth Edition of the New Jersey Formulary*—which may be cited NJF-V. If you have not received your copy, write to the Executive Offices at 315 West State Street, in Trenton. The 5th edition, unlike its predecessors, lists by English rather than Latin titles. All USP and NF preparations have been deleted, since these official items are already so well described in their respective volumes. Eight new preparations have been added. These are:

1. Cherry Vehicle
2. Kaolin Mixture with Pectin
3. Ferrous Gluconate Syrup
4. Zinc Chloride Mouth Wash
5. Hemorrhoidal Suppositories
6. Sulfadiazine Syrup
7. Sulfathiazole Syrup
8. Benzyl Benzoate Emulsion

Since *Cherry Vehicle* was introduced some months ago, a number of pharmacists have stated that it would not suspend aspirin, acetophenetidin, and other insoluble drugs. The preparation is not intended to be used as a suspending agent. Its primary use is as a solvent for water-soluble drugs where a sugar-containing vehicle is contra-indicated. The acacia in *Cherry Vehicle* increases the viscosity so that it has the thickness of a syrup. There is not enough acacia to be of value as a suspending agent.

Kaolin Mixture with Pectin has been introduced to fill the need for a liquid antacid and diarrhea preparation. It is compatible with the usual medications ordinarily prescribed in the treatment of diarrhea. Such preparations as Paregoric, Belladonna Tincture, or Opium Tincture mix readily with the *Kaolin Mixture with Pectin* which gives it a decided advantage over preparations of a similar nature already on the market.

Ferrous Gluconate Syrup has been included to fill the demands for an iron-containing syrup. This may be prescribed as a vehicle for thiamine hydrochloride. Ferrous gluconate was selected because of its stability, solubility, and the comparative ease with which it can be incorporated into a syrup.

Besides the additions, revisions have been made in several of the former preparations. *Green Phenobarbital Elixir* is identical in potency with the official U. S. P. elixir, but is colored green instead of red. This formula merely establishes standards for a preparation therapeutically equivalent to the official elixir that may be used in cases where a green elixir is preferred.

Thiamine Hydrochloride Elixir has been increased in potency two and one-half times, from 3 milligrams of thiamine hydrochloride per fluid ounce, to 7½ milligrams. This increase was made because of the tendency today to prescribe thiamine in larger doses than was done when the elixir was originally introduced. The formula which was given in the supplement of N. J. F. IV included glucose in place of syrup. Syrup, now more readily available, has replaced the glucose. The preparation contains 50% syrup in order that the final produce will have a total of not less than 40% solids. It is necessary that this amount of solid material be present, otherwise the preparation would be classed as an alcoholic beverage according to the regulations of the Food and Drug Administration.

Solution Ephedrine Compound, Isotonic, has been changed somewhat in that sodium chloride has replaced part of the dextrose as one of the agents regulating the tonicity. Directions are also given in this preparation for the addition of sulfathiazole or sulfadiazine so that they may be used in combination with the ephedrine when indicated.

Some of the titles have been changed as follows: *Cherry Syrup with Ammonium Chloride* is now the official title for a preparation which in the 4th edition was listed as "Ammonium Chloride Cough Syrup". *Orange Syrup with Sodium Citrate* is the official title of the former "Sodium Citrate Cough Syrup". The prescription listed for treatment in acute cystitis or pyelitis has been given the official title of *Potassium Citrate Solution with Tincture of Belladonna.* The name of Targyrum Ointment has been changed to *Coal Tar Ointment with Mercuric Salicylate.*

MEETING OF WELFARE COMMITTEE

SUNDAY, SEPTEMBER 14, 1947

STATE SOCIETY HEADQUARTERS, TRENTON

ATTENDANCE:

Dr. Vincent P. Butler, Chairman
Dr. Royal A. Schaaf

Dr. Edward Guion, Atlantic County

Dr. John L. Olpp, Bergen County
Dr. Harold C. Essertier

Dr. Paul R. Sparks, Burlington County
Dr. R. Winfield Betts
Dr. William E. Bray

Dr. H. Wesley Jack, Camden County

Dr. Samuel B. Hughes, Cape May County

Dr. Albert B. Kump, Cumberland County

Dr. J. Wallace Hurff, Essex County
Dr. Thomas W. Harvey

Dr. Wendell J. Burkett, Gloucester County
Dr. Chester I. Ulmer

Dr. Berthold S. Pollak, Hudson County

Dr. Samuel Blaugrund, Mercer County
Dr. L. Samuel Sica
Dr. John L. Wikoff

Dr. Ralph J. Faulkingham, Middlesex County

Dr. C. Byron Blaisdell, Monmouth County
Dr. Stanley Nichols
Dr. Louis F. Albright

Dr. Salvatore Giordano, Morris County

Dr. Homer H. Cherry, Passaic County
Dr. H. Hale Hollingsworth

Dr. Lewis C. Fritts, Somerset County

Dr. Frederick W. Lathrop, Union County
Dr. Herschel S. Murphy
Dr. Thomas J. Walsh

Dr. Ralph M. L. Buchanan, Warren County

GUESTS AND CONSULTANTS:

Dr. J. O. Hill
Dr. George Blackburne
Dr. Norman M. Scott
Dr. Earl H. Snavely
Dr. S. William Kalb
Miss Anna J. Haines
Dr. Edward P. Duffy
Dr. J. Howard Hornberger
Miss Louise Rogers
Dr. Elton W. Lance
Dr. C. Chester Chianese
Dr. William E. Dodd
Dr. Carl Weigel
Mrs. William E. Dodd
Mrs. Lodovico Mancusi-Ungaro
Mrs. Asher Yaguda
Dr. D. Bergsma
Dr. Sigurd W. Johnsen
Dr. H. E. Reading
Dr. H. C. Burkhead
Dr. Joseph F. Londrigan
Dr. T. K. Lewis
Dr. Nicholas S. Ransohoff
Dr. Asher Yaguda
Dr. Jerome G. Kaufman
Marjorie Shearon, Ph. D.
Emil Frankel, Ph. D.
Dr. Frederic J. Quigley
Mr. William MacDonald
Mr. James E. Bryan

Chairman Butler opened the meeting at 2:00 p. m. and introduced as guest speaker, Marjorie Shearon, Ph.D., Washington, D. C., formerly analyst to the Social Security Administration and U. S. Public Health Service; for the past two years legislative consultant to the Senate Committee on Labor and Public Welfare; now operating her own *Shearon Medical Legislative Service*. Dr. Shearon is the publisher of a weekly bulletin on federal legislation, *American Medicine and the Political Scene*. Dr. Shearon delivered an address, which, in abstract, follows:

DR. SHEARON (in abstract): One basic issue in the 1948 presidential campaign will be whether a "welfare state" is to be established in this country. By a "welfare state" I mean a central government which would provide a wide range of cash, service, and other benefits to the entire population at public expense and which would control the people by "regulative interference". Justification for this is the alleged need of the people for greater economic security, better nutrition, and sounder health. The more abundant life, it is claimed, can be obtained only through federal intervention and the development of a national welfare program to protect the entire population from life's major hazards.

President Truman has already called upon Congress to enact health and welfare laws. The legislation thus far introduced to implement this would gradually transform our system into a "welfare state" which, for centralization of power and of public revenues, would surpass the communist state in Russia and the socialist state in Great Britain.

First step in creating such a planned or compulsory economy would be a federal law for national social insurance either through piecemeal legislation or through a series of bills purportedly for the general welfare. Blueprint for this is the comprehensive Wagner-Murray-Dingell bill of 1943 and the more grandiose omnibus bill in 1945. This over-all blueprint for comprehensive compulsory national social insurance should be kept in mind because it is the *sine qua non* of a "welfare state". The law *must* be comprehensive, it *must* be com-

pulsory, and it *must* be national if the planned welfare state is to be set up.

National social insurance, it must be remembered is designed to do three things: raise revenues; control people; and redistribute wealth and income. Universal sickness insurance is one of the control measures. The full extent of the plans for governmental interference cannot be appreciated by studying piecemeal legislation. Isolated bills cannot be divorced from their context of omnibus compulsion. One must not lose sight of the long-time objectives while quarrelling over the detailed provisions of separate bills.

Until the passage of the Social Security Act in 1935, our experience with compulsory insurance had been limited to State Workmen's Compensation laws. In the 1935 Social Security Act, major emphasis was placed on old-age insurance because of its great popular appeal and seeming social justification. Unemployment insurance was almost equally popular as the country emerged from the long siege of unemployment in the early thirties. The Act likewise provided modest grants-in-aid for expanded public health services and for assistance to dependent children, the aged, and the blind. Few saw reason to fear or distrust a law providing federal aid and even compulsion for social objectives seemingly so desirable.

Had we then seen the total scheme in the minds of the planners who pushed the Social Security Act through Congress (and who a little earlier maneuvered us into the socialist dominated International Labor Organization), we might have paused before embarking on a program so alien to our way of living. Instead we unwittingly accepted the basic tenets of collectivism as opposed to those of individualism.

REGULATIVE INTERFERENCE

The Social Security Act bears the label "made in Germany". Its roots are in Bismarck's program for state socialism. To understand the *real,* rather than the *avowed,* purposes of the Act, one must turn to the objectives set forth by Bismarck and his adviser. According to Bismarck's plan, the state was gradually to assume ownership of banking, insurance, and communications and was to set up a system of "insurance against sickness, incapacity, and old age". The hard-pressed German Chancellor proposed a pay-roll tax, which, it was asserted, would serve the dual role of raising revenues and of bringing about the desired "regulative interference" with the lives of the people.

The "interference" was designed to bring under federal regulation the distribution of income and wealth and the purchasing power and living habits of the "lower classes". The latter form of "interference" was to be accomplished by administrative rules and regulations and by compulsion. Bismarck's economic adviser stated, "This two-sided policy of taxation I call social. The second side here advanced. . . . . is based, as concerns the mass of the population, the lower laboring classes, on the assumption that in the truest interests of the nation a guardianship may and must be exercised over the national consumption or even the application of income to personal purposes."

Bismarck's social insurance laws were congeries of laws embracing political and economic devices rather than genuine social measures. Social insurance is neither social nor insurance; it merely provides an ingenious taxing system and a clever device for "regulative interference" by an all-powerful central government.

The first national compulsory sickness insurance law, enacted in Germany in 1883, became the model for similar laws in thirty countries. It also established the technics of intrigue, misrepresentation, and dishonest propaganda which have always marked the stormy path of compulsory legislation. Essentially the pattern is as follows: bills are drafted by non-medical, government "experts" in the Executive Departments which are seeking increased power. The medical profession is by-passed entirely or consulted perfunctorily. Tax rates are decided upon and are as large as the traffic will bear. Authority is given to officials to draft regulations for administering the program. The legislation is sold to the public, to the legislative body, and to labor by misrepresenting the objectives, the contemplated methods of administration, and the end results. In our day freedom of choice is promised to physicians and patients alike; benefits are glowingly described; costs are scarcely mentioned. The scheme is publicized as an insurance law under which beneficiaries are *entitled* to complete medical care as a "right" by virtue of a token payment in the form of payroll taxes.

SOCIAL INSURANCE AS A "RIGHT"

It was Bismarck's idea that the so-called "lower classes" could be sold on the principle of "compulsion" and would submit to control by a powerful bureaucracy if they were promised certain benefits, including Government-controlled medical care, as a "right". The bitter pill of compulsion was to be sugar coated with the false claim that workers would henceforth be "insured" by the State and would thus avoid the stigma of public charity.

The same sales talk is being used today in this country in selling the Wagner-Murray-Dingell bill. Benefits are maximized, costs minimized. Although our national income is nearing the annual rate of $200 billion, arguments based on national needs when our income was one-fifth that amount are still being solemnly presented to justify federal intervention in our daily lives. Senators, obviously misinformed about the legislation, are duped into lending their names and prestige in support of measures they would never support if they understood. I do not doubt that President Truman himself has been sold a bill of goods without having any real appreciation of the long-range implications of parts of his legislative program.

Let me illustrate by giving a few examples of the glaring misrepresentations disseminated by federal officials and by those members of Congress who take their cue from such officials. Physicians are told that they will have a voice in deciding whether payment is to be made on the basis of capitation, fee-for-service, or salary. This myth was

exploded when, under the penetrating cross-examination of Senator Donnell of Missouri at the health hearings this year, Michael M. Davis, one of the prime-movers for the nationalization of medicine admitted that ultimately we would come to a capitation system if the Wagner-Murray-Dingell bill were enacted. Dr. Ernst P. Boas has likewise stated that "Insurance guaranteeing complete medical coverage cannot be set up, except at prohibitive cost, if the fee-for-service principle is retained".

If the Wagner-Murray-Dingell bill is enacted, our entire population would ultimately be herded into a panel system like that which obtained for 35 years in Great Britain and which served as a precursor to current plans for a salaried service. Patients would become federal pawns, worth so much per head per year to the physicians on whose lists they appeared. We are promised that patients would be free to reject the benefits of national social insurance and that physicians would be free to remain outside the system if they wished. But the officials who make these promises *know* they are not speaking the truth. They *know* that a considerable portion of the population could not pay the increased social security taxes of 6 per cent on payrolls (together with the increased income taxes) that would be required to finance the social insurance deficit and at the same time to pay for private medical care. These officials *know* that doctors would ultimately be forced to sign on as federally controlled insurance doctors unless they adopted a national policy of non-cooperation as was done in Australia, is contemplated in Great Britain, and has been proposed in this country. Suppose part of the profession were to sign up? This would start with the least capable physicians and with communist sympathizers. Then there would be increasing difficulty for the remaining members of the profession to retain their freedom. The area of private practice would dwindle through a slow process of erosion. General practitioners would be squeezed out of private practice as competition from insurance practitioners increased. Specialists would find it impossible to reach a sufficiently large population from which to develop an adequate practice.

A SINGLE NATIONAL MEDICAL SERVICE

The International Labor Organization, which twenty years ago revised Bismarck's blueprint for socialized medicine and proposed the principles now being followed in this country by the authors of the Wagner-Murray-Dingell bill, stated in 1942 that:

". . . . once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other. The next step to a single national medical service is a short one. . . ." (Emphasis mine).

If the Wagner-Murray-Dingell bill is enacted and the federal officials who drafted it retain their present positions, you may rest assured there will be little or no consultation with medical groups in the writing of the all-important regulations which would control not only all the health professions, but also hospitals, health centers, medical schools, and research centers.

Federal sickness insurance alone would give federal officials access to anywhere from *six to ten billion dollars a year* of tax funds. The total social security program when fully mature would take at least 20 per cent of the national income. If the planners should succeed in their schemes, they would induce Congress to transfer the tax-collecting power from the Bureau of Internal Revenue to the Federal Security Agency. They would control the national social insurance trust fund as Hitler did. To entrust such vast sums to a few federal officials (who are not elected representatives of the people) is, it seems to me, sheer folly. No bureaucrat and no political party should be able to control such funds and such power. These same officials would recommend to Congress ways in which the trust funds should be spent. They would determine capitation rates, hospital rates, and other scales of payment for services. Doctors' pay scales would be determined by the amount in the health insurances fund and by the whims of Federal officials who were drafting the provisions for regulative interference.

THE PHANTASY OF PROMISE

One of the promises repeatedly made by Senators Murray and Pepper is that everyone would have a complete physical examination every year. A little elementary arithmetic will show the fallacy of this. If 125,000 physicians spent their full working time of 2,000 hours a year on physical examinations for all the people, they would have less than 2 hours each to give to each person *and there would be not a single physician available for anyone who was ill.* The promises of the federal propagandists are utterly fantastic. The bill has been called a fraud on the American public. As a matter of fact, the federal government might well find itself in the position of the New Zealand Government which sold the people short by promising services it was not able to deliver. New Zealand finally said to its people, in effect: "If you can find a doctor who will treat you on the terms laid down by the social insurance law, we will foot the bill." But it was a case of first catch your doctor.

TECHNICS OF PROPAGANDA

There has been established in Washington a well organized propaganda machine inside the federal government. It is operated by Federal Security officials who openly flout Congress and daily break federal laws by misusing federal appropriations. They control the media for dissemination of information. The Bureau of Research and Statistics in the Social Security Administration has prepared numerous reports for Senate committees. The central theme of these documents is that only through

federal "health" insurance can the health of the nation be improved and adequate medical care given to all the people. They have never explained by what legerdemain they expect to give to everyone all the promised services without running up the costs to prohibitive figures. Apparently they are following Hitler's advice about propaganda. He said:

"All effective propaganda has to limit itself only to a few points and to use them like slogans. . . . It has to appeal forever and only to the masses. . . . The more modest then, its scientific ballast is, the more it exclusively considers the feelings of the masses, the more striking will be its success."

Thus the slogans of the federal government propaganda machine which is financed exclusively, from tax funds, and of the cooperating nongovernmental lobbies are as follows: "Health insurance is *not socialized medicine.*" "Health insurance must be *compulsory.*" "Medical services must be available as a *right.*"

These propagandists have worked closely with the two private lobbying groups, the Physicians Forum, (whose chairman is or was a member of eight communist-front organizations) and the Committee for the Nation's Health, which is particularly active at Senate hearings. Both these groups use the communist organization, the International Workers Order, as an outlet for publications. Recently the Committee for the Nation's Health prepared material for a film to be distributed by the IWO. The Social Security Administration, the Public Health Service, and the Farm Security Administration furnished pictures to the IWO for the same propaganda film strip. Publicity for the film appeared in the *Daily Worker* of June 2, 1947.

The International Workers Order is one of the strongest and most active communist organizations in this country. Founded in 1930, it follows the Moscow line. An essential part of its program is the establishment in the United States of a comprehensive social insurance system along the lines laid down in the Communist International. The IWO has supported each of the Wagner-Murray-Dingell bills. The organization sent an admitted communist to testify this summer in favor of S. 1320. The primary objective of the IWO is the overthrow of our form of government and the establishment of a communist state. This is the organization which is aiding in the propaganda for the "welfare state" and which in turn is being aided by federal officials.

SIGNS OF AWAKENING

This situation is now under investigation by the Harness Subcommittee on Publicity and Propaganda. Hearings have been held in the House and one report has already been published. A large number of officials in four bureaus in the Federal Security Agency have been charged with misuse of federal funds for the purpose of socializing medicine. The Subcommittee voted unanimously to request Attorney General Clark to investigate the lobbying activities of those officials who long have endeavored to foist upon the American people an alien system of national social insurance as a prelude to establishing a "welfare state" under federal control. The Department of Justice has referred this entire matter to the FBI which two weeks ago started its own investigation, attention being centered on the Bureau of Research and Statistics in the Social Security Administration.

During August, Representative Harness called attention to the fact that some of the same federal officials whose activities were even then under investigation were planning to fly to Japan to sell the Wagner-Murray-Dingell bill to the Japanese. The Harness Subcommittee requested that the mission be delayed pending the results of the investigation. Nothing could illustrate more clearly how hell-bent these government officials are to do as they please, regardless of federal laws and of the wishes of a Congressional committee, than the complete disregard they showed for requests to delay the mission to Japan. The mission departed on August 28. The four officials who went have long been associated with the leader of the nationalization movement in the United States. The Commissioner of Social Security, Arthur J. Altmeyer, together with other federal officials, all of whom are under investigation by the FBI, plan to proceed to Japan a little later, at the taxpayers' expense. An omnibus national social insurance bill of the Wagner-Murray-Dingell type is to be ready for the Japanese Diet by October 1, with the aid of the members of the mission to Japan. Compulsory legislation which our own Congress has refused to accept for this country may yet be foisted on the Japanese if we do not intervene.

In the meantime the Harness Subcommittee is continuing its skillful probe of the Federal Security Agency all through the summer. It has descended on the files of the Social Security Administration unearthing letters and other documents which demonstrate how closely the Bureau of Research and Statistics worked with the newspaper *PM*, with lobbying groups, union officials, and the International Labor Organization.

Senate hearings on health legislation will be resumed in January. Isidore S. Falk, Director of the Bureau of Research and Statistics, will be recalled to continue testifying on his activities as leader of the nationalization movement and as the most active federal lobbyist for compulsory sickness insurance.

For the first time it seems likely that there will be brought into the open the full story of the effort of a handful of federal officials to grab control of vast federal trust funds and to establish a "welfare state" in the United States. Until the activities of these officials are fully aired and the law has been invoked against them, there is small chance of any true cooperation between the states and the federal government in working out a genuine national health program.

The officials now under investigation have not inspired confidence; their reports have been discredited; the reliability of their interpretations of factual material has been challenged at the Senate hearings. Their integrity has been questioned. It is a matter of grave concern to every citizen when a federal official fails to regard a public office as a public trust. It is a national calamity when that

same official, driven by an overweaning urge for power, endeavors surreptitiously to sell state socialism to the Congress in the guise of legislation allegedly for the general welfare.

Dr. Guion moved that Dr. Shearon's paper, either in entirety or in abstract, be published in the JOURNAL. Seconded and unanimously carried.

DR. QUIGLEY: Mr. Chairman, I think it would be valuable if Dr. Shearon would speak briefly about the political scene in Washington as it is beginning to unfold. She knows what I am talking about.

DR. SHEARON: We have the omnibus, the Wagner-Murray-Dingell Bill and a lot of little bills pushed in, in the hope that they will get through Congress peacefully. They assume that these bills will go through because so many Congressmen have no idea of what they contain but may pass them so they will stand in well for the coming election. This is the first time we have had health measures put into an administrative program. All federal agencies are expected to be in favor of federal legislation on health measures. Some, but not all, Republicans are opposed to compulsory health insurance. There are some who might go along on the compulsory insurance bill, if it was a close draw and they felt that they had to give "something to the people".

There is a real threat this year because Congress is totally uninformed. They do not know what is in the bill with the exception of two or three of them. Medicine and other groups with a common interest should get together instead of each group playing tiddley winks by itself.

DR. BUTLER: Can you tell us, Dr. Shearon, something about your pamphlet, the *Blueprint for the Nationalization of Medicine?*

DR. SHEARON: This booklet is the prime reason why Senator Murray had me fired so it must be very good. I gave his name as a propagandist connected with the inside and outside, though it did not show his tie-in with socialized medicine. I priced the pamphlet *Blueprint for the Nationalization of Medicine* at 25 cents, which does not pay me for the job but I wanted to get it into every physician's hands. The state of Oregon purchased two thousand copies and gave a copy to every doctor in the state, I hope New Jersey can do the same.

DR. SCHAAF: I would like to thank Dr. Shearon. We can all profit by what she has said.

At the last meeting of the Welfare Committee in May we still had been unsuccessful in our search for an Executive Officer and it ended sooner than we thought it would because we re-opened negotiations with Mr. Bryan. After Dr. Wilkes' death we were at loose ends as far as public contacts were concerned. Mrs. Madden has done a valuable job for the past number of years, and we hope that she will continue along the same lines. We now have the man who we think is going to fill the vacancy which was created by the death of Dr. Wilkes. I am greatly pleased to present Mr. Bryan.

MR. BRYAN: Dr. Schaaf has given me a great deal to live up to. It has been said that one of the prime duties of a public relations man is to work on our relations with the public, the public being the members of the Society, cooperating outside organizations and the general public.

Public Relations is not a special kind of profession or bag of tricks that one can utilize to produce a favorable impression. Public Relations of any group, is a direct reflection of what they are themselves. I am proud to be associated with The Medical Society of New Jersey. I have known from outside for years of your effective work, of your progressive attitude to the public, of the devotion of your officers and the high quality of your work in general. Even while you were looking for a public relations man, you have always had good public relations. Your point of contact with state government and public organizations has been almost unmarred by any unfortunate events. Perhaps there is a great deal that can be done to make that relationship more intimate, more mutually trustworthy. I welcome the opportunity to try.

DR. NICHOLS: I want to welcome the opportunity to express what this means to the N. J. Health Congress, to the Welfare Committee, to the secretaries and presidents of the county societies that have come to hear the excellent paper of Dr. Shearon's. I am hoping she is made an honorary life member.

In 1931 The Medical Society started on its public health program and in that report we said that if the medical profession itself would not assume leadership in solving problems of public health, medical care that politicians would be only too glad to take it over. Sixteen years later I stand here to say the same thing is true. You need to know a word or two about the N. J. Health Congress as we need all of your help. The A.M.A. House of Delegates in 1944 passed a resolution to promote voluntary medical care. The Medical Society of New Jersey thereafter initiated this N. J. Health Congress for this purpose. It has one purpose only, and that is the inter-

change of ideas and joint conference studies of the quality, quantity, availability, and distribution of health services rendered by the allied health professions, with constructive recommendations to participating agencies, to the end that good quality health services shall be available to all the people. Membership is composed of delegates from three groups: first, those who render health services; second, those who receive health services; third, state governmental agencies officially concerned with health services. The organization was started in 1946, and with Mr. Bryan's help we will have it completed within this year.

By the time Congress meets and the presidential election is on the way, there is going to be, from what Dr. Shearon says, legislation from Congress as to health care so that we have just one year to develop something real. I hope you have a clear understanding of what we are preparing to do to take back to the county medical societies. Dr. Scott's Committee is going to make a real study of plans for medical care. The important thing that Dr. Scott's committee can produce is a blue print but until the county societies put it on the local level it is not going to do any good. I urge all of you to read *Medicine and the Changing Order* which can be purchased from the Commonwealth Fund in New York for $2.00.

Dr. Scott: The Committee which Dr. Nichols referred to is one to formulate plans under which medical care would be made available to every person in New Jersey. We have had difficulty in interpreting the functions and objectives assigned to that Committee under the resolution, "to crystalize the mechanism of approach to the problem of providing good medical care for every citizen". One point of view was that we were to make medical care available to everyone, that is, to all people regardless of income. We should not invade the area represented by those persons who are able to arrange for their own medical care. There was so much confusion in interpreting the resolution that it is being referred to the Trustees for clarification.

REPORTS OF SUBCOMMITTEES

Dr. Pollak read the report of the Subcommittee on Legislation (see page 421, this issue). On motion of Dr. Schaaf, this was accepted with an amendment to name Dr. Quigley as a consultant to accompany our delegates to the next A.M.A. convention, all expenses paid.

Dr. Murphy reported for the Subcommittee on Medical Practice. (This report, together with action taken, will be found on page 419, this issue). As amended, the report was approved.

The report of the Subcommittee on Public Health was made by Dr. Blaugrund. This report was approved. (See page 422, this issue).

Dr. Sica presented the recommendations of the Public Relations Subcommittee, which were then approved by the Welfare Committee.

The Welfare Committee voted to ask the Board of Trustees to authorize designation of Dr. Scott and Mr. Bryan, as well as Dr. Quigley, as consultants to the delegates to the next A.M.A. convention, all expenses to be paid by The Medical Society of New Jersey.

The Committee adjourned at 4:30 p. m.

SUBCOMMITTEE ON PUBLIC RELATIONS

SEPTEMBER 14, 1947

The Executive Officer will serve as Executive Secretary, ex-officio of the Public Relations Committee. The Committee recommends the following expanded program.

1. Increase use of radio in providing health information to the public—A.M.A. transcriptions; experimentation in "live" programs.
2. Re-establishment of Speakers Bureau.
3. Continuation of *Health Hints* column in newspapers and industrial magazines.
4. Promotion of the October "Public Health Week" programs; organize State-wide event for the fall of 1948.
5. Active cooperation with the New Jersey Health Congress.
6. More pamphlets for public distribution.
7. Monthly *News Letter* to membership.
8. A vigorous press release service.
9. County Society visitation by the Executive Secretary.

L. S. Sica, M.D.,
Chairman.

SUBCOMMITTEE ON MEDICAL PRACTICE

SEPTEMBER 14, 1947

Dr. Yaguda introduced two resolutions. The first resolution was as follows:

> That we recommend to the Board of Trustees that the State Board of Medical Examiners be requested to furnish an interpretation of the Medical Practice Act (particularly section 45:9-15) as it pertains to the practice of clinical pathology, and that the State Board of Medical Examiners be asked to bring a test case into the courts.

Dr. Yaguda explained that this concerned the operation of clinical laboratories by persons who were not physicians. Since clinical pathology has been considered (by both the A.M.A. and our state society) as a specialty within the practice of medicine; and since the *diagnosis* of diseases is included within the legal definition of medical practice, it might appear that the non-medical directors of laboratories were, in effect, practicing medicine without a license to do so. We had been advised by counsel, however, that there was no way of knowing whether the courts would so interpret it, unless a test case were brought before the proper tribunal. Dr. Quigley reported that this had been discussed with the Assistant Attorney General who was quoted as "dubious of success in prosecuting such a test case". Dr. Quigley felt that before this resolution was passed, it would be wiser to consult further with the Society's counsel and with the Attorney General's office. The Subcommittee finally decided to table action on this resolution until the December meeting, with the understanding that in the interim it would be studied by both the Subcommittee on Legislation and by the State Board of Medical Examiners.

Dr. Yaguda then introduced the following resolution, which was approved and referred to the Trustees for action:

> *Whereas,* the Board of Trustees fixes the basic policies of The Medical Society of New Jersey, and
>
> *Whereas,* the Board of Trustees has indicated by resolution that the practice of anesthesiology, radiology, physio-therapy and clinical pathology are branches of the practice of medicine and that exploitation of these medical services by hospitals and hospital service plans violates the principles and ethics of the American Medical Association, and
>
> *Whereas,* committees of The Medical Society of New Jersey are recommending actions in violation of the above stated policy of the Board of Trustees and of The Medical Society of New Jersey;
>
> *Therefore,* be it resolved that:
>
> The Board of Trustees call to the attention of all its committees, its policy and views in this matter and request that committees take no action in violation of this policy.

Dr. Snavely reported for the Hospital Relationships Committee that one of the hospitals in the state had asked for a ruling on the question of charging the staff members a fee for each hospital admission. Dr. Snavely's committee met during the summer and while they disapproved of the situation, they recognized the emergency of the hospital's finances and gave temporary approval until The Medical Society could act upon it. The Medical Practice Committee, looking at it as an over-all proposition, decided that whether it was voluntary or otherwise it could easily grow into an abuse and went on record as emphatically disapproving of such an arrangement at any time, as it borders upon fee splitting. If the Welfare Committee approves our attitude and the Board of Trustees approve of our action, a copy should be sent to N. J. Hospital Association and each hospital of our disapproval of this type of tax.

After hearing this report, the Subcommittee recommended that the Welfare Committee and Trustees be asked to voice disapproval of any scheme whereby hospitals would ask physicians to make a contribution (voluntarily or otherwise) for each patient admitted.

Dr. Henry A. Cotton, Jr., Deputy Commissioner, Institutions and Agencies, came with a *Manual of Standards for Private Hospitals in New Jersey.* He asked for a study and for tentative suggestions from the Medical Practice Committee in the next month. Realizing that our next Welfare meeting would not be until December 14, it was suggested that the chair appoint a special committee from the Medical Practice Committee to study this manual. The chair appointed Dr. Marquis, Chairman, Dr. Yaguda, Dr. Snavely, Dr. Blackburne, and Dr. Murphy together with Dr. Cotton, to meet on October 5. Dr. Scott, Dr. Schaaf, Dr. Quigley and Mr. Bryan are also asked to meet with the committee.

The Subcommittee reviewed and approved the following definition of a Health Center as drafted by a special committee of the Welfare Committee.

> A Public Health Center shall be construed to be a publicly owned or controlled building or part thereof providing office quarters for the official health unit supplying public health services for a pre-

scribed area having at least 25,000 population, together with facilities for demonstrating and applying disease preventive measures and for carrying on the generally recognized public health services and facilities for such additional health services as are provided for by the local community, with the cooperation of the physicians of the state through the county and state medical societies, or as a public service and if practical, with office quarters for other agencies voluntary or otherwise performing health services in the area.

Further, we construe an Auxiliary Health Center to be a place located within the area prescribed for a Public Health Center, operated as supplemental to and under the auspices of such Center and having facilities or furnishing services in a limited degree such as are available in or furnished from the Public Health Center.

Dr. Marquis made a progress report on the survey of radiologists in New Jersey for the Advisory Committee on Radiology.

Dr. Blackburne, Chairman of the Medical Care of the Indigent Committee, made a progress report on the Newark Plan.

Dr. H. Wesley Jack, Chairman, made a progress report for the Nursing and Nursing Education Committee.

Dr. William K. Harryman, made a progress report on compensation fees as Chairman of the Workmen's Compensation Committee.

The Medical Practice Committee discussed a letter from the radiologists about telephone listing of specialists in the classified section of the telephone books. It was felt that this subject had sufficient merit to justify the appointment of a special committee by the chairman of the Medical Practice Committee from among its members. This committee will study the matter and at a future meeting will render its report and present it to the Welfare Committee.

H. S. Murphy, M.D.,
Chairman.

TROPICAL DISEASE NOTES

Although it is often said that there need be no fear of tropical diseases in the United States, recent American literature contains a number of articles on this subject. Furthermore, many grants-in-aid for tropical medicine have been made recently. The government has set up centers of specialized treatment for tropical diseases in present and former personnel of the armed forces.

Why are tropical diseases receiving so much attention now? One reason, of course, is the presence in the country of hundreds of thousands of veterans of tropical service. Another major factor is the increased contact with tropical food, drink and living afforded by increased air, sea and motor travel.

Certainly malaria and dysentery occupy a prominent place in the medical literature and professional thinking of physicians today. Histoplasmosis, for instance, is supposed to be a "rare tropical disease". Yet cases have been observed in nineteen states.

NOTES ON MALARIA

Properly administered, quinacrine (atabrine) is better than quinine.[1] It is true that some subjects exhibit untoward gastro-intestinal symptoms as a result of the initial administration of quinacrine. Furthermore, it gives only temporary protection in *plasmodium vivax* infection[2] though in adequate dosage it completely cures falciparum malaria.[3] Chloroquine or SN 7618 is highly effective in acute attacks of vivax malaria,[4] while paludrine is a suppressive of falciparum infection.[5]

NOTES ON AMEBIASIS

Emetine in enteric coated capsules or tablets is successful in amebiasis though twice the subcutaneous dose over a period of 21 days may be required. In the chronic phase, carbarsone, alternating with vioform is recommended. In excess, all three are toxic drugs. Emetine in enteric coated tablets is well tolerated in doses up to four grains a day.[6] In intractable amebiasis, a relapse is possible if only a single course of anti-amebic treatment is given.[7] Carbarsone, chinioform and vioform are effective[8] in the treatment of healthy carriers of *entameba histolytica* and other protozoa.

Christian P. Segard, M.D., Chairman
Committee on Tropical Diseases.

1. Bulletin, N. Y. Academy of Medicine, 21:467 (1945).
2. Journal, American Medical Association, 132:623, November 1946.
3. New England Journal of Medicine, 234:519, September 1946.
4. Journal, American Medical Association, 131:963, July 1946. Also, see Journal of The Medical Society of New Jersey, 43:368, September 1946.
5. Lancet, 1:278, March 1946; and Journal of The Medical Society of New Jersey, 43:368, September 1946.
6. American Journal of Tropical Medicine, 26:293 (1946).
7. Military Surgeon, 99:273, October 1946.
8. American Journal of the Medical Sciences, 213:608, May 1947.

SUBCOMMITTEE ON LEGISLATION

SEPTEMBER 14, 1947

The Society has reason to view with satisfaction its accomplishments in State legislation over the past several years. No inimical public health legislation has been passed during this period, and every measure sponsored by the Society was promptly enacted into law. We may count ourselves fortunate. However, there have been indications that this happy situation may not long continue unless there is wider public understanding and support of the position of the Society with respect to certain bills which (we expect) will again be introduced at the next, and, very likely, succeeding sessions of the Legislature. When almost the sole opposition to bills which would make possible the licensure of graduates of sub-standard medical schools and totally unqualified cultists comes from the medical profession, it is extremely difficult to persuade many legislators that our opposition to these measures is not motivated by self-interest.

It is with particular satisfaction and relief that this committee views the advent of the new Executive Officer, Mr. Bryan. Mr. Bryan's experience and demonstrated capacity in public relations leads us to hope that the effect of his activities in this field may soon be reflected in our legislative work.

There were two bills before the last session of the Legislature which would have made possible the licensure of graduates of sub-standard medical schools. We assume, of course, that it is the desire of the Welfare Committee that similar bills, if introduced at the forthcoming session, be vigorously opposed. It would be helpful if we had specific directions from the committee to this effect.

An official summary of the provisions of the proposed new State Constitution makes it incumbent upon the Legislature to consolidate the 80-odd departments and agencies of the State government into not more than 20 departments. In view of this, it hardly seems possible that the Board of Medical Examiners will remain a separate entity, but will be placed in some department, presently existing or to be created. The medical and allied societies should give prompt thought as to where they would like to see their examining boards placed. There is one thing that we should make every attempt to do, and that is to preserve as completely as possible the autonomy of the Board of Medical Examiners.

On January 6, 1948, the second session of the 80th Congress convenes. All bills which were introduced at the first session of this Congress not already disposed of are alive and ready for further action. Hearings on the Taft-Smith-Ball-Donnell bill, and on the Wagner-Murray-Dingell bill, are scheduled to resume in January. Mention should be made of two bills of special significance introduced in the closing days of the first session of this Congress. Senator Pepper of Florida introduced S-1714, *which would make permanent the emergency maternal and infant care program.* The bill calls for approximately $20,000,000. for the fiscal year 1949; $30,000,000. for 1950; and such sums thereafter as Congress may determine necessary for the expansion of grants-in-aid to states for maternal and child health services. Senator Murray of Montana has also introduced S-1734 providing for a *national system of unemployment and cash-sickness benefits.* In connection with this last-mentioned bill, it should be recalled that, at the 1946 session of Congress, an amendment to the Railroad Retirement Act providing for cash-sickness and maternity benefits was enacted into law. The A.M.A. took no position on this while this legislation was pending.

If agreeable to the Welfare Committee, we propose that an adviser to our delegates to the A.M.A. be appointed to accompany the delegates to the meetings of the A.M.A. and to act in a consultative capacity in matters of legislation. We suggest that this be forwarded to the Board of Trustees.

The suggestion was also made that the bulletins of the Shearon Legislative Service be abstracted and published from time to time in the Journal. It is suggested that because of the penetrating analyses of bills made by this bureau, all county societies shall be urged to subscribe to this service and endeavor to secure individual subscriptions from members interested in legislation. If 100 or more subscriptions can be obtained, it would be possible to secure these at $8 per person.

Note was made again of the fact that apparently there will be no member of The Medical Society in the New Jersey Legislature this year. This is a matter of vital concern and the committee suggests that efforts be made by all counties to see if there is a possibility of having a physician on the Assembly ticket.

Respectfully submitted,

B. S. Pollak, M.D.,
Chairman.

SUBCOMMITTEE ON PUBLIC HEALTH

SEPTEMBER 14, 1947

The Tuberculosis Committee requested that a correction be made in their program as detailed on page 155 of the April (1947) JOURNAL. The corrections will consist of inserting the words "tuberculin-positive" before the phrase "school-children" in item 6, and again before "students" in item 7. As corrected, the lines would read:

6. X-raying of all tuberculin-positive school children.

7. Annual radiologic surveys in schools for personnel as well as for tuberculin-positive students.

The request was granted and the correction ordered published. The subcommittee next heard the recommendations of the Child Health and Maternal Welfare Committees with respect to standards for decreasing neo-natal mortality. The following discussion took place:

DR. MURPHY: This recommendation has been examined by the Medical Practice Committee. It was felt that more complete study should be given before acted on. It was felt that it should be studied by the Committee and reported on at the December 14 meeting.

DR. NICHOLS: Dr. Cotton would like something definite on this recommendation before December 14, as he is anxious to include this in the *Manual* he is working on and that would be much too late.

DR. MURPHY: Why not refer this recommendation to the special committee already appointed to study the *Manual?* They will have the power to act. They are meeting with Dr. Cotton on October 5.

It was moved that the recommendations of the Advisory Committees, Child Health and Maternal Welfare be referred to the special committee of the Medical Practice Committee at its meeting on October 5 with Dr. Cotton and that this committee have the power to act. Motion carried.

Dr. Reading: Those who are familiar with the Wagner-Murray-Dingell Bill will remember they referred to the crippled child as a "handicapped child". The problem at the present time is the opening of four clinics for the treatment of cases of cerebral palsy. Neither this Society nor any of its committees were asked about the advisability of these clinics or for assistance in staffing them. They are located in Elizabeth, Long Branch, Trenton and Passaic. In addition a doctor who has just finished a graduate course will be full time physician for these four clinics. The National Society for Crippled Children is interested in this field. A representative of that Society talked to me six months ago and her idea was to approach the committees of this Society before beginning any program. Nothing has been heard from them since then. I feel that the State Society should do something about this program which is now entirely out of hand.

DR. RANSOHOFF: The spastics and their families were advised that a special doctor was coming into Monmouth County. They were told to report to him as he was to have a spastic clinic. Parents actually came to me with tears in their eyes to say that they simply did not want to go to that clinic. I had to tell them that if they feared that something would happen to them if they didn't report, they ought to go ahead to the clinic. Two months later, I was informed that the Crippled Children's Commission was opening a clinic in Long Branch, so I got in touch with Mr. Leon and also with Mrs. Wiegle. I told them that this was a direct infringement on the practice of medicine. They said they would take it up with the Commission. I explained that we have sufficient facilities to take care of crippled children. If the load got too heavy, all they had to do was furnish us with another physiotherapist. This is an important problem from the standpoint of possible state medicine. It was clever of the state to use this problem as an entering wedge for the state practice of medicine.

It was agreed to refer this matter to the Trustees for further guidance.

ORTHOPEDIC BED SPACE AVAILABLE

Adult bed space has been materially increased at the Hospital and Home for Crippled Children in Newark. The medical staff invites all qualified orthopedic surgeons to make use of the expanded and modernized facilities of this hospital. The department of physical medicine is especially well equipped, and now has a therapeutic pool. Inquiries should be directed to the medical director, Hospital and Home for Crippled Children, 89 Park Avenue, (corner Clifton Avenue) Newark 4, N. J.

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Chairman Nutrition Committee

This page should serve as a medium to help the average physician with his problems on nutrition as they may occur in his routine office practice. The answers which are given to the questions are usually simple and concise without a lot of chemical formulas and without too much detail. At times they may even appear elementary but the fact that they are understood by, and helpful to those who want the information should be sufficient to prove the value of this mode of exchange.

The Journal of Endocrinology contains many scientific and super-scientific articles which are not understood by the average physician and not even by the specialists in endocrinology. Many protests arose as a result of the way these articles were published. As a result of the protests the Association for the study of Internal Secretions decided to publish a Clinical Journal of Endocrinology which would depict articles in a more clinical style and which would be more appealing and readily understood by the profession. This too has now become a highly scientific periodical which even the endocrinologists find it hard to understand. It is this sort of confusion that we want to get away from.

A "chemist" reviews our page of March 1947, and makes the following comments:

Thiamin, "which is the most important vitamin present" in left-over meat, is not lost in reheating.

Comment: Query the Bureau of Home Economics of the U. S. Department of Agriculture for the abundant references which contradict this statement of the "stability" of thiamin. Also, why is thiamin "most important"? The lipotropic factor, inositol; the cell-growth factor, biotin; the zymotic factor, riboflavin; are these less important? (Not less important in value but less important in common usage.)

"If no amphetamine is being given, prescribe niacinamide" with a reducing diet.

Comment: Administration of large doses of niacin will cause excretion of pyridoxin, and may contribute to fatty infiltration of the liver. Why not the entire Vitamin B Complex? And what is the pharmacological inter-relationship contraindicating simultaneous use of amphetamine and niacinamide? Also, since calcium pantothenate deficiency also causes pain in the extremities, why indicate niacin? (No relationship at all, my poor chemist. Amphetamine is the drug most commonly used in reducing and also causes cramps in legs.)

"Milk and vegetable fats have the same food values". Do they?

Comment: Milk is consistently lower in unsaturated fatty acids than many vegetable fats; these are the only fat principles definitely known to be essential in animal nutrition. Also, milk fats are nearly always richer in Vitamin A, and possibly in Vitamins K and E than vegetable fats. (Clinically there is no difference. Many biochemists agree with this.)

Yeast, "splendid source of the Vitamin B Complex, contains an insignificant amount of purine."

Comment: No such generalizations can be made: many varieties of yeast are not "splendid" but only fair sources of certain B Complex factors, such as niacin; also, many yeasts do contain sufficient purine bodies to exacerbate gout in a sensitive patient. (We are discussing only the yeast products available to the public found in grocery and drug stores.)

These are not isolated examples, but culminate a long series of inexplicable errors in fact marking this feature of your otherwise useful publication.

I have received letters at various times from chemists who take issue with the manner in which the answers are presented. I have the deepest respect for the contributions which have been made in the field of nutrition by the chemists but some of them have a lack of knowledge in the clinical administration of their research.

This is left entirely to the doctors and only they can evaluate the effectiveness of drugs and diets in the various deficiencies. It is therefore important that doctors understand the pharmacology of vitamins, minerals, and amino acids. A working knowledge of the scientific principles of dietetics is necessary.

INTERNATIONAL COLLEGE OF SURGEONS

Dr. Watson B. Morris, chairman of the Board of Regents, International College of Surgeons, announces the recent election to Fellowship in that organization of 25 New Jersey practitioners. Their names follow:

Kenneth L. Athey, Camden
John J. Bedrick,* Bayonne
Fred J. Crescente,* Paterson
Alfred D'Agostini,* Newark
Louis Davis, Newark
William Doran, Jersey City
William B. Ein, Newark
Benjamin Glass, Plainfield
Joseph Gutowski, Perth Amboy
William Harryman, Hackensack
Joseph Imbleau, Unionville
Meyer Kern, Newark
Harry P. Landis, Jr., Palmyra
William A. Loeb, Lyon
Albertos Maldeis, Camden
John Masterson,* Irvington
Joseph A. Miller, South Orange
Anton P. Randazzo, Passaic
John V. Reilly,* Newark
Abraham A. Rubin, Bellevilie
Anthony Sellitto, South Orange
Edwin A. Steiner, Newark
Martin Swiecicki, Barrington
Louis Wegryn,* Elizabeth
Arthur S. Wilner Trenton

* To Associate Fellowship.

OBITUARY

DR. JAMES S. PLANT

One of the truly original thinkers in American psychiatry, Dr. James S. Plant, director of the Essex County Juvenile Clinic, died on September 7, 1947. A native of Minneapolis, Dr. Plant attended the medical school of the University of Pennsylvania from which he was graduated in 1918. After several years with the famous Judge Baker Foundation (a privately supported psychiatric clinic in Boston) he came to New Jersey to direct the Essex County Juvenile Clinic. He was the first and only director this agency ever had. And in the growing roll-call of tax supported psychiatric clinics in the United States, the Essex County unit is number one. It was the first of its kind in the country. Its success was the inspiration of many others. And its success was due principally to the labors of Dr. Plant.

Dr. Plant's unique contribution was a workable fusion of dynamic psychiatry and modern pediatrics. He was one of the earliest practitioners to link these two specialties. He entered the field at a time when the Freudian concepts had reached the apex of their popularity, with a resultant tendency on the part of psychiatrists to underemphasize the social and cultural forces which shape personality. More than any other man in the country, Dr. Plant kept orthopsychiatry in the main stream of social science. His book, ***Personality and the Cultural Pattern*** swept over the fields of psychiatry and pediatrics like a fresh breeze. It was certainly the first text which ever gave adequate emphasis to environmental and social factors in moulding human behavior. When, for instance, Dr. Plant preached that delinquency could be more readily prevented by slum clearance than by psychiatric clinics, he was suspected of heresy. But a generation of psychiatrists and pediatricians have since come to accept as commonplace, the importance of "the cultural pattern". As much as any idea is ever assignable to a single mind, that idea is the contribution of James S. Plant.

His reports to referring doctors, his frequent lectures, and his extraordinary book, served as the media through which he communicated his ideas. Because he was, by nature, so self-effacing, the stature of the man was not fully appreciated by some of his brother-practitioners. It is probable that even today, many local physicians will be surprised to hear that James S. Plant of New Jersey was one of the top-men of American psychiatry. But to all pediatricians and psychiatrists throughout the country, who are sensitive to trends in their specialties, his name is well known. He was chairman of the Executive Committee of the National Committee for Mental Hygiene—the latter being the prime mental hygiene organization of the world. He was an active member of the White House Conference. He enjoyed many other honors, too. But more important than these formal tokens of his position in American medicine, was his position in the affections of the many young psychiatrists and pediatricians whom he helped. They will long remember the well-packed pipe, the cheery round face, the silver hair and the richly timbered voice which led so many discussions on problems of human personality. He was only 57 years old when he died. It seems much too soon for so many of us in two professions to have to say "good bye" to a valued friend.

VETERANS CARE PLAN

To promote more efficient operation of the Veterans Administration home-town medical care program through members of the Medical Society, it is appropriate to review the essentials of procedure.

All members of The Medical Society of New Jersey are eligible to participate in the program because of the contract between VA and the Medical Service Administration. Questions regarding the qualification of specialists should be forwarded to me for further clarification.

When a veteran visits you for medical care, he should be referred to the nearest VA office to obtain an application for out-patient medical care. He will notify VA that you are his physician. VA will send forms to you, one of which will be a request for authorization. Giving VA a brief description of the veteran's condition is desirable. Always state how many visits are anticipated for the remainder of the month. This is only tentative. An authorization for a certain number of visits is not a demand that so many be made, for the Medical Society is committed to a policy of administering only the necessary medical care to veterans.

VA cannot pay for medical care unless VA authorizes it. Nor can VA authorize medical care when notified by the physician more than 15 days after the care was administered.

When the case appears to be an emergency, you should phone VA (collect)) at MArket 3-6800, Extension 440; or call the out-patient treatment section of the VA office in Union City or Trenton * should they be nearer.

HOSPITALIZATION

When the veteran requires hospitalization, telephone MArket 3-6800, Extension 432 to obtain proper authority. If a veteran has already been admitted to a hospital, VA must be notified within 72 hours. The veteran may not be an eligible VA beneficiary. If hospitalization is required for a psychiatric disorder, ask for extension 429.

ANAESTHETISTS

Physician-anaesthetists sometimes have difficulty in getting paid for administering anaesthesia to VA beneficiaries. Here, also, VA must be notified within 72 hours regarding the type and duration of the anaesthesia so that authorization may be made to the physician. *The surgeon's authorization does not include fee for anaesthesia.*

WHICH VA OFFICE?

If authorizations originate in more than one VA office, communicate thereafter only with the VA office handling the case for the particular veteran. The place of origin of the authorization will be found in the upper left-hand corner.

CONTINUATION OF TREATMENT

A very large volume of work slides into VA during the last few days of each month. For that reason, physicians are urged to make requests for continued treatment by the 23d, which gives VA time to get out the authorization for the beginning of the next month. Include all the VA beneficiaries under your care on the single form.

GP—SPECIALISTS RELATIONSHIP

The VA recognizes only one physician as handling a veteran's condition. This physician does not relinquish his command when the opinion of a specialist is needed unless the practitioner notifies VA that the specialist is to be authorized to treat the veteran.

The physician in charge tells VA the name of the specialist desired, so that they may send him the authorization. Specialists should not render an opinion or treatment for a VA beneficiary without determining whether the physician first seeing the patient has notified VA and has made a definite request from VA for the type of examination or amount of treatment desired by the specialist.

BILLING

The procedure for submitting invoices (on Form 10-2568 "Authorization and Invoice for Medical Service") requires that the physician prepare on the reverse side of the two carbon copies of the authorization his invoice for services rendered. Two carbon copies of a bill are *not* acceptable for payment. The physician should retain, for his own records, the typed original copy of the Authorization.

Submit your invoice as soon after the services, as authorized, are rendered; or when the period covered by the authorization has expired.

REMEMBER

The Liaison Officer, who is the Medical Society representative at Newark Regional Office, VA, 20 Washington Place, Newark 2, desires to assist physicians and VA so that veterans may receive adequate medical care.

EDWARD T. YORKE, M.D.
Liaison Officer.

* If the veteran lives in Hudson, Bergen or Passaic counties, call the Union City office at Union 7-3307. If he lives in Hunterdon, Mercer, Monmouth or any counties south of these, call the out-patient treatment section of the Trenton office (Trenton 4-7191); otherwise, call Newark.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

In the fiscal year ending June 30, 1947, the Bureau of Bacteriology completed its busiest period in terms of specimens examined for doctors and health authorities throughout the state. A total of 360,105 serologic, bacteriologic and parasitologic specimens were examined, not to mention more than 2000 Rh determinations. The latter were done as a convenience to the doctors since this determination is not a routine procedure in the laboratory.

The number of specimens this year increased 38,822 over that of the last fiscal year. The following table gives a numerical picture of the steady rise (except during the war years) in the requests for specimen examinations to the Bureau of Bacteriology:

1940	201,418
1941	305,276
1942	321,837
1943	341,071
1944	285,537
1945	276,610
1946	321,610
1947	360,105

Most of the increase in the number of specimens examined belongs in the serology service: 307,432. This figure is the number of specimens examined and does not show the total procedures, as many bloods need repeat tests, and those showing a reaction in the initial Mazzini are checked by the Kahn complement fixation and the Kahn flocculation test.

STREPTOCOCCAL DISEASE—RESPIRATORY

Streptococcal disease—respiratory is a desirable term for epidemiologic purposes for such syndromes as scarlet fever, scarlatina, streptococcicosis, streptococcic tonsillitis, nasopharyngitis, "septic sore throat", etc. Much progress in understanding streptococcal disease was made during the war and it is ably summarized and discussed by Francis F. Schwenker in a paper entitled "The Epidemiology of Streptococcal Infections" in the *Journal—Lancet* (Minneapolis) of May, 1947. All health officials, pediatricians, school officials and many others can study this paper with interest and profit.

In careful studies of streptococcal disease carried out over an appreciable period "every single type [at least 46] was recovered at least once. All types were found almost everywhere". Several different types were responsible for any one syndrome in an outbreak but these differed from one place to another and from one time to another in the same place. Types of streptococci were observed to (1) lose their apparent pathogenicity, (2) maintain an unvaried career and (3) suddenly acquire a marked increase in pathogenicity.

"The streptococcal picture in any locality is a constantly changing one. It is never static."

There are a dozen unknown carriers for every case. Carriers as individuals are usually far less dangerous than "cases" but in the aggregate, may, because of their numbers equal or exceed cases as a hazard. Carriers are not all equally dangerous. *Nasal carriers are by far the most dangerous.*

"Everyone is now convinced that quarantine of active cases has little or no value from a public health standpoint in diseases like streptococcal infections."

"In my opinion, at the present time, any attempt to recognize and segregate carriers is impractical."

The use of sulfa drugs and antibiotics prophylactically is discussed as well as ultraviolet barriers, vaccination and physical methods of control.

VOCATIONAL REHABILITATION FOR CIVILIANS

A new pamphlet designed specifically for the medical profession concerning the state-federal program of vocational rehabilitation for the general population has been prepared by Senior Surgeon Thomas B. McKneely and Senior Surgeon Charles L. Newberry, both U. S. Public Health Service.

Its purpose is to point out several ways in which medicine can add another instrument to its professional armamentarium, add another service to its patients, and assume its rightful place in the files of vocational rehabilitation.

Copies have been sent to all physicians and additional copies are available from the Federal Security Agency, Office of Vocational Rehabilitation, Washington 25, D. C.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

Under the chairmanship of DR. CLARENCE WHIMS, its president, the *Atlantic County Medical Society* held its regular meeting on Friday, September 12, 1947. Dr. Whims introduced the guest speaker, DR. JOSEPH C. BELL, of Louisville, Kentucky, who spoke on *X-Ray Examination in the Diagnosis of Malignant and Potentially Malignant Lesions of the Large Bowel.*

Dr. Bell stated that the day was past when obscure carcinoma of the large bowel is seen; it is more apt now to be seen early and with varied symptoms. Outstanding symptoms are bleeding, pain and loss of weight. The essential procedures in a routine examination are careful history, careful physical examination, ordinary laboratory studies and a routine digital, sigmoidoscopic and proctoscopic examination. He stressed the fact that 50% of all cases of carcinoma of the large bowel can be detected by digital examination.

The radiologist plays an important part in this routine examination and formulates his opinion only after careful preparation of the patient and after adequate films have been taken. Many small serial films may give additional information. Carcinoma is a constant finding and in many cases only repeated examination with serial films will indicate if it is constant. Fluoroscopy alone may miss a lesion but adequate films will show it, especially a carcinoma of the colon.

Lateral films of the rectum will disclose early lesions and these can be followed up by sigmoidoscopic examination.

Spasm will cause a defect in the large bowel, but if it is a carcinoma, it will be constant in repeated film examinations.

Slides were shown to illustrate a great variety of cases of carcinoma of the large bowel and diffuse polyposis by roentgen films. Dr. Bell discussed these cases from the standpoint of diagnosis and the important part the roentgenologist plays in clarifying the malignant from the non-malignant lesions.

Dr. Whims then introduced DR. GILBERT HEUBELEIN of Hartford, Connecticut, who spoke on *Diffuse Pulmonary Lesions.* He showed films demonstrating the various densities of the lung fields and presented many cases to illustrate the pitfalls and difficulties in diagnosis.

BERGEN COUNTY

H. E. Relnhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society,* Bergen Pines Hospital, Oradell, N. J., on September 9, was called to order by the president, DR. RUDOLPH C. SCHRETZMANN, at 9:15 p. m.

On recommendation of the membership committee, the following were elected to full membership: DRS. WINTON H. JOHNSON, Hackensack; JOHN E. MCWHORTER, Englewood, and NELSON C. WALKER, Hackensack. DR. VINCENT A. SCIALLI of Ithaca, N. Y., was elected to Courtesy Membership.

DR. WILLIAM H. STONER of the Medical Research Department of Schering Corporation, formerly Assistant Professor of Bio-chemistry and Disease of Metabolism at the Graduate School of Medicine, University of Pennsylvania, discussed *the source and methods of abstraction of the various hormones, their rating and methods of assay,* while DR. ELMER L. SEVRINGHAUS, Director of Clinical Research of Hoffmann-LaRoche, formerly Professor of Medicine, University of Wisconsin, and DR. WILLARD H. SOMERS, Englewood Hospital, discussed *the physiology of the male and female hormones and their therapeutic use in disorders of menstruation and the climacterium, prostatic disease and cancer, angina pectoris and endocrine diseases.* These discussions and ideas were all well received, and it would seem that this will induce the program committee to schedule other panel discussions as a variation from the traditional lectures.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The first meeting of the *Burlington County Medical Society* for the current season was held on September 11, at the Riverton Country Club. With profound sorrow to all of the members, the death of Dr. Gerald E. McDonnel was announced. Dr. McDonnel was killed on September 3, 1947, in an automobile accident near Mt. Holly. On April 7, 1947, Dr. Joseph Stokes, Sr., died. At the time of his death he was the oldest member of the society.

Due to the untimely death of our president Dr. Gerald E. McDonnel, DR. E. WARREN RODMAN of Beverly, who was the president-elect, became president of the Burlington County Medical Society.

Guest speaker of the evening was DR. CHARLES BAILEY of the Hahnemann Hospital, Philadelphia. He spoke on *Cardiac Surgery,* and reported that the oldest operation on the heart was pericardial paracentesis. He described the old procedures and the new. He discussed briefly the treatment and symptoms of stab wounds of the heart and told some amusing stories about the etiology of the stab wounds. To illustrate the technic of pericardiectomy to alleviate constrictive pericarditis, he showed an instructive colored motion picture, during which he described orally what was taking place in the picture.

The essayist then reviewed operations on the great vessels in the region of the heart. The conditions he discussed were: Patent ductus arteriosis; congenital pulmonary stenosis; coarctation of the aorta; double aortic arch; the division or moving of large vessels causing pressure on the trachea and esophagus; and the surgical treatment of mitral stenosis. In each case he described the surgical procedures and what improvement was to be expected in the patient's condition. He laid stress on early treatment of patent ductus arteriosis. Concerning the treatment of congenital pulmonary

stenosis, which has not been too successful, Dr. Bailey described for the first time before any medical society the new surgical procedure to correct this condition. Although still in the experimental stage, it does promise relief for those unfortunate people. His lecture was interesting and gave the members of the society new hope for patients suffering from the conditions he described.

Dr. Norman K. Boudwin of Beverly was elected a new member of the Burlington County Society on a transfer from the Camden County Medical Society.

Dr. E. Vernon Davis was elected treasurer to replace Dr. Anthony Ziccardi, who is now taking a residency at the Margaret Hague Hospital.

GLOUCESTER COUNTY

L. K. Collins, M.D., Reporter

With the president, Dr. Joseph Hughes, in the chair, a regular meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, September 18, at 9 p. m.

Elected to full membership were: Dr. James Dickensheets, Dr. A. J. Battaglia, and Dr. Warren Bundens, Jr., all of Woodbury.

Following a discussion initiated by Dr. William Pedrick, the society went on record as opposing mass x-ray surveys at fairs and carnivals. It was felt that such an exhibition was a mockery of medicine and that adequate facilities are now available at our chest clinics. Dr. Pedrick stated that neither the Gloucester County Health Association, of which he is president, nor the Gloucester County Medical Society had been consulted prior to the x-ray survey at the recent Gloucester County Fair. This matter was to be called to the attention of the Board of Trustees of The Medical Society of New Jersey.

Dr. Wendell Burkett gave an interesting report on state and national legislative activities. He particularly mentioned the fine work of Marjorie Shearon, Ph. D., who is now operating an information bureau on federal legislation. This excellent service may be made available to all members at a nominal fee in the near future. Dr. Burkett reminded the members that we all need to do our part in the forthcoming legislative work.

Dr. J. H. Hornberger, State president-elect, gave a few words outlining Dr. Schaaf's plans for the year. We were urged to continue to cooperate with the Veterans Administration in the "home-town" treatment program, and also to expand our public relations work. The scientific program consisted of two interesting A.M.A. films on *The Diagnostic Significance of Alterations in Gait".*

SALEM COUNTY

D. G. Neander, M.D., Reporter

The first fall meeting of the *Salem County Medical Society* was held on September 19, at the Du-Pont Penns Grove Club. The meeting was called to order by the president, Dr. William H. Miller.

The minutes of the last regular meeting were approved as read by the secretary.

After the reading of several communications, a motion was made and passed to investigate the possibilities of organizing a Woman's Auxiliary to the Salem County Medical Society.

Dr. James S. Shipman of Camden, was the speaker of the afternoon. Dr. Shipman discussed some of the problems of the eye which the general practitioner faces. In his discussion, Dr. Shipman particularly emphasized the need of referring patients with eye problems to an ophthalmologist, and also the necessity for early eye care for children.

After the meeting was adjourned, the members of the Society enjoyed dinner served at the Club.

UNION COUNTY

Edward G. Bourns, M.D., Reporter

The last meeting of the season was held by the *Union County Medical Society* at Ciba Pharmaceutical Products, in Summit, on May 14, 1947, with Dr. Stanton H. Davis, the president, in the chair.

Dr. Stevenson, member of the Program Committee, introduced Dr. Charles Lee Buxton, Instructor in the Department of Obstetrics and Gynecology, College of Physicians and Surgeons, New York, who spoke on *The Use of Hormones in Sterility.* It was a most interesting discussion and extremely well presented.

The Secretary read a letter from the Union County Welfare Board regarding the new fee schedule which now permits the payment of $2 for office calls and $3 for home calls for patients who are wards of the Board. The Director expressed appreciation of the doctors' cooperation in the past and hopes that the members of the Society will accept the new fee schedule.

Candidates elected to membership were Dr. Edward R. Haykins of Elizabeth, Dr. Sidney R. Livingston and Dr. Kenneth H. Scott of Plainfield.

The chairman of the advisory committee to the Visiting Nurse Association reported on a meeting held by the committee to discuss several problems presented by the V. N. A., namely: (1) Daily and every other day orders on intra-muscular injection which requires a visit on Sunday with special reference to liver extract. This uses nurse power which must be replaced during the week and is difficult to make up. (2) Patients have doctor's prescriptions refilled without the knowledge of the doctor. V. N. A. should know number of doses ordered by physician. (3) Patients who can pay and demand daily general bedside care when they are up and partly about. (4) Chronic cases who need care, not seen by a doctor for several months, if they do not develop acute condition.

It was agreed that the new fee schedule of $2 for office calls and $3 for home calls be adopted in caring for patients who are wards of the Union County Welfare Board.

A delightful supper was served the members by Ciba and this meeting closed the 1946-47 season. Dr. Davis announced that the program committee was arranging to have the September outing as so many of the members expressed the desire to have it again this year.

WOMAN'S AUXILIARY

MIRIAM LEE EARLY LIPPINCOTT

On August 28, 1947, death came to one of New Jersey's best-known women, Mrs. Miriam Lee Early Lippincott.

Mrs. Lippincott always will be remembered as a woman of many talents and accomplishments. Her affiliations with organized civic, welfare, educational and philanthropic organizations were numerous.

She was known to all of the federated clubs in New Jersey as well as to other women's organizations in many parts of the United States. If the cause of an organization was deserving and Mrs. Lippincott believed in it, she not only accepted membership but contributed to its objective from the vast store of skill and energy with which she was so liberally endowed.

Several years ago, she received an award as Camden County's most outstanding woman—an honor from her fellow citizens which was richly deserved. The award was officially presented through the Soroptomist Club following a vote taken by the membership of every other women's organization in the County.

Mrs. Lippincott was a trained public speaker and a reader of great dramatic ability. Of these gifts, she gave liberally to aid in organizing and developing the many organizations with which she was affiliated.

One of her interests was the Little Theatre movement. For this as well as for many other organizations she selected the cast for many plays, coached the actors and in many instances took part with personally enacted dramatic entertainment.

She was a member of the Camden Women's Club for more than 30 years and served as its president from 1927 to 1930. Under her leadership the club flourished and prospered. An adjoining building was purchased and the club room enlarged.

Only a few days before her death, Mrs. Lippincott expressed to the writer, a hope that the Camden Women's Club, in which she had great faith, never should pass out of existence.

During her presidency of the organization, she was honored by the club through a contribution to the New Jersey College for Women to be applied to the building of a music room. A plaque stating that the contribution had been made in memory of Mrs. Lippincott's



daughter, Barbara Lee Early Lippincott, was placed in the room.

Mrs. Lippincott was a pioneer in promoting the cause of woman suffrage. After women received the ballot, she expressed regret that more of them did not exercise the right of franchise and participate more fully in public affairs. She, herself, was active for many years in the cause of temperance.

In the field of education, Mrs. Lippincott was a liberal contributor. She taught dramatic art at Swarthmore College for a number of years. She was a trustee of Rutgers University. One of her special interests was the New Jersey College for Women. She provided annual scholarships at that institution for four "exceptional and worthy" girls.

Mrs. Lippincott maintained close contact with the recipients of these scholarships, following their careers and acting as counsellor and advisor and, in most instances, bestowing upon them a motherly affection.

Twenty years ago she organized a Woman's Auxiliary to The Medical Society of New Jersey of which her late husband, Dr. A. Haines Lippincott, had at one time been president. Mrs. Lippincott also organized county auxil-

iaries throughout New Jersey. She was the first state president of the Auxiliary and several years later became president of the Camden County Auxiliary.

In The Medical Society of New Jersey all past presidents are honored by the title of "Fellow". Mrs. Lippincott organized past presidents of the auxiliary into a similar unit with the title of "Fellowettes".

She was chairman of public relations of the National Auxiliary of the American Medical Association.

Shortly before the beginning of World War II, she became chairman for New Jersey for the United China Relief. In that capacity, she contributed countless hours of service in the sale of Chinese commodities to raise money for relief work in China. She gave lectures, and organized units in all parts of the state. During this time she was selected by Rutgers University to confer, *in absentia*, an honorary degree upon Madame Chiang Kai Shek.

Mrs. Lippincott's last, great crusade—towards the control of cancer—will undoubtedly be known as her greatest contribution to the welfare of mankind.

She became interested in the fight against cancer about ten years ago. To this cause she gave her all, working day and night, regardless of weather, time or anything other than that her services were needed in the great battle against mankind's most deadly enemy. She was adjudged by the American Cancer Society as the lay person best equipped to launch, organize and administer the service and educational phases of the work.

During her years of service she made thousands of speeches before almost every organized group in the state—service clubs, women's clubs, churches, schools, granges, and others. She will always be remembered, because of her affective contributions to the work, as the "Cancer Lady".

No person in New Jersey has contributed so much or so liberally to the cancer control program as Mrs. Lippincott. It was she who built the foundation upon which the organized cancer control program in this state was erected. She contributed her time, her talent, and her means to promote interest in the cause.

Because of her many good deeds the world has been enriched. The fields over which she labored have been made to flourish. Barren soil has been made to an acreage of good works.

Mrs. Lippincott was indeed a true friend. Those of us who were privileged to work closely with her will feel her loss keenly. The fields of service which she selected for her life work have been swept by many storms. Mrs. Lippincott weathered them all. Her house of service was not built upon the sand but founded upon the firm rock of faith and belief.

In the words of another great American woman—Ella Wheeler Wilcox—

She "set her soul to determine her goal;"
One ship sails East; another West
And the self-same breezes blow.
'Tis the set of the sail and not the gale
That determines the way they go.
Like the winds of the sea are the currents of earth
As we travel along through life;
'Tis the set of the soul that determines the goal
And not the storms that are rife.

Mrs. Arthur J. Casselman

PRESIDENT'S MESSAGE

There is no place for lukewarm enthusiasm in an organization concerned with issues of vital interest to all of us. An all-out effort should be made to revitalize the Auxiliary in all of its component parts as we start our fall activities.

First effort should be to increase the membership of counties already organized. Dr. Bortz, president of the American Medical Association, has asked that the membership of the National Auxiliary be doubled during his administration. On the basis of our membership it then follows that our quota is 2000. Every Auxiliary member of the larger counties should bring in two new members, since the new membership potential of some of the smaller counties is almost nil.

At a state level, organization work is being carried on to remove the measles from the face of New Jersey. This blight of unorganized counties appears on the face of New Jersey on the map of the membership chairman of the National Auxiliary. To be exact, we have eight cases with one on the road to recovery.

The officers of the Woman's Auxiliary to The Medical Society of New Jersey are anxious to eradicate this malady, and are request-

ing that members knowing wives of physicians living in the counties of Bergen, Cape May, Cumberland, Hunterdon, Morris, Salem, Somerset, and Sussex, approach them, tell them of the need for an Auxiliary, and interest them in forming one, or in becoming members-at-large.

Frances Mancusi-Ungaro.

SALUTE TO CAPE MAY

The Woman's Auxiliary to The Medical Society of New Jersey salutes Cape May County Medical Society whose members have so graciously received the State Auxiliary president and who have now formally agreed to the formation of an Auxiliary.

Letters have been written to each physician of the county society asking him for the names of the eligible members of his family (mother, wife, unmarried daughters and unmarried sisters) so that invitations may be forwarded to them. The names of widows of physicians living in that county have also been requested.

The Auxiliary earnestly appeals to each physician of The Medical Society of New Jersey to give serious consideration to the work of Organization Chairmen, Mrs. Thomas P. McConaghy and Mrs. C. Chester Chianese.

COUNTY AUXILIARY MEETINGS

Camden Public Relations.	October 28
Passaic	October 20
Warren	October 21
Atlantic	November 14
Burlington	November 10
Gloucester	November 18
Hudson	November 3
Middlesex	November 19
Union	November 18
Warren	November 18

COUNTY PROJECTS

Atlantic County

Mrs. Edward H. Dyer, President

The sponsoring of a student nurse, as in previous years, is one of the projects of Atlantic County for this year. The nurse is to be aided financially during her period of training. A Sweepstakes Dance will be held to augment the funds in the Student Nurse Project.

A Reciprocity Tea, with the Woman's Club of Atlantic City, is planned as a part of the Public Relations program.

Burlington County

Mrs. E. Vernon Davis, President

Again this year, as in the past eleven years, we are concentrating on our pet project which we term our "student nurse scholarship". Every three years we appoint a committee to select a girl from one of our communities who is in need of financial aid and who desires to enter a hospital to begin student nurse training. She may choose the hospital, and we then take over by assuming all expenses until she graduates. It has been very gratifying in the past years to see what splendid nurses have been aided by our efforts. We undertake other smaller projects each year but feel our main one is student nurse.

Camden County

Mrs. Arthur G. Pratt, President

The members of the Woman's Auxiliary to the Camden County Medical Society have before them many worthwhile and urgent goals for the coming year.

However, it would be most gratifying if, through the many committees working on program, public relations, charity fund projects, membership drives, and hospitality plans, 100 per cent of our members take an active part, in some way, in the year's activities.

Gloucester County

Mrs. Chester I. Ulmer, President

The need to increase nurse recruitment so that the high level of American medical service may be maintained is particularly recognized by the medical profession. This urgency has developed into a project in our Gloucester County Auxiliary and we have created a student nurse scholarship this year.

A committee comprised of our graduate nurse members headed by Mrs. William Beall of Clarksboro, was appointed to select a worthy young woman from our county to be the recipient of this scholarship. The honor was given to Miss Ruth Murphy of Richwood, who will begin her training at Cooper Hospital, Camden on September 1.

In a broader sense, we hope by our example to interest other organizations in this type of sponsorship. Thus we will indirectly assist promising young women to enter the nursing profession and increase the number of much needed nurses.

Hudson County

Mrs. Louis L. Perkel, President

The theme of my regime is Friendship. Toward this end, two hundred and seventy-six invitations have already been sent to eligible new members. We plan to give a tea, in honor of the new members, at our opening meeting on Monday, October 6. Several parties, bridges, fashion shows and a dance are planned to stress Friendship. Of course, we intend to continue working on the cancer, tuberculosis and polio drives. We shall continue to give, yearly, a Bond as prize to the winner of our Freile Memorial Essay Award Contest. This is given to the senior high school student who writes the best essay on a medical subject. The subject is chosen by the Auxiliary.

Mercer County

Mrs. E. F. Purcell, President

The Auxiliary to the Mercer County Medical Society for the past few years have had as one of their projects the financial aid of a student nurse. Every three years a committee is appointed to select a high school graduate who has a sincere desire to become a nurse, but is unable to pursue this career due to financial circumstances. The third nurse to benefit from the assistance of the Auxiliary is now in her second year of training and president of her class. Two previous nurses have graduated and become a credit to the nursing profession. A report is given at each meeting concerning the progress and needs of the student nurse.

Middlesex County

Mrs. Nathan Karshmer, President

The Auxiliary to the Middlesex County Medical Society begins the year 1947-48 with the advantage of a membership 50 per cent larger than it was one year ago. This gain is due to the sustained drive for members undertaken by the Auxiliary last year. Since many of our members are new and unfamiliar with the objectives of the organization, it is our aim to inform and interest them so that the major goals of the Auxiliary can be accomplished. We hope to fulfill these plans through good programs at our meetings and through a wider participation of all members on our committees. One of our projects this year will be the planning of a Public Relations meeting to be held later in the season.

Passaic County

Mrs. Albert G. Markel, President

The Woman's Auxiliary to the Passaic County Medical Society is deeply interested in two specific projects. The first is a rheumatic heart disease program for children. We have our share of cardiac cripples, and it is felt that the Woman's Auxiliary could contribute by donating a few essential needs, such as equipment. Our second project is the creation of a fund for subsidizing the nursing education of a worthy applicant, in a local hospital.

Warren County

Mrs. Walter Boquist, President

The object of the Woman's Auxiliary to the Warren County Medical Society is to create more interest in the medical and health problems which are of local importance. With that in view, we are sponsoring various methods of raising funds to provide needed equipment for our local hospital.

BOOK REVIEWS

A Textbook of Medicine. Ed. by Russell L. Cecil, A.B., M.D., Sc.D., with the assistance of Walsh McDermott, M.D. Associate ed. for Diseases of the Nervous System: Harold G. Wolff, M.D. 7th ed. 1730 pp. and 377 illus. Phila and London, W. B. Saunders Co., 1947. $10.

This edition, published less than four years after the first "war-time" edition, is the most up-to-date and complete one volume practice of medicine.

There are sixteen new articles on subjects not covered previously, and fifty-six new treatises on subjects previously covered. Careful study of the new material is equivalent to graduate study, and very fine for the returning veteran, too.

Special attention is drawn to penicillin therapy in pneumonia and syphilis, the anti-malarial drugs, the use of heparin and dicumarol as anti-coagulants in the treatment of thrombosis and phlebothrombosis, and the rationale of endocrine therapy. If you are interested in the effects of the atom bomb, read about radium poisoning and about the selective deposition of radioactive isotopes in the tissues.

Vitamin K deficiency is discussed. Post-operative bleeding occurs if prothrombin concentration is less than 20 per cent of normal. The value of following the prothrombin level in surgery of the new-born is emphasized.

Revised concepts about hemoglobinuria are explained. Accumulation of hemoglobin products in the renal tubules is the result, not the cause, of impaired renal function and decreased output. Hemolytic transfusion reactions with reference to the Rh factor are explained.

The mechanism of migraine is interestingly presented, with emphasis on the relations to feelings of insecurity and frustration.

Psychosomatic medicine is "good medicine, well practiced". The role of overactivity of the autonomic nervous system, and secondarily the endocrine glands, expressed in end organs by spasm of the smooth muscle is considered. An example of the application of the better knowledge of physiology is the treatment of gastric ulcer by the teamwork of the physiologist, surgeon and psychiatrist. The inter-relation of emotional and physical disturbances is nothing new, but it has been ignored too much in the past. Vagotomy, frontal leukotomy, splanchnicectomy result from the newer attack on the treatment of certain disturbances.

This reviewer would like to see a little better amplification of the treatment of the various diseases, but that more rightly belongs in a book on therapeutics. It is hard to separate the practical from the theoretical knowledge. Frankly, I am more than satisfied with the book in its present state.

James R. Lomauro, M.D.

Preoperative and Postoperative Treatment. Second Edition. Edited by Lt. Col. Robert L. Mason, M.C., A.U.S., and Harold A. Zintel, M.D. Pp. 584 with illustrations. Philadelphia and London, W. B. Saunders Company, 1946. $7.00.

This is the second edition of an important book, the first edition having appeared nine years ago. In the intervening years many important advances in medicine have occurred which have caused great changes in the preoperative and postoperative care of the surgical patient. These changes have focused attention on greater utilization of the basic sciences in promoting earlier recovery and in the lowering of mortality and morbidity.

Nearly every chapter of the previous edition has been almost entirely rewritten; the book has been completely reset. Chapters have been added, also sections of chapters, including a consideration of physical medicine in surgery; pre- and postoperative care in gynecology; pre- and postoperative care in surgery of the stomach and duodenum; intestinal obstruction; nutrition in surgery; surgical risk in pregnancy; thrombophlebitis; Vitamin K therapy; and emergency care of cranial injuries.

The authors state that successful surgical treatment has come to mean not only the removal of diseased structures, but also the restoration of normal function. They believe that an understanding of pathologic physiology is necessary to plan operative procedures in such a way that the ill effects of the condition are overcome before surgery, and thus will more speedily return the patient to normal activity.

This book should be recommended to all physicians in the practice of surgery as well as to those who devote part of their time to surgical work. The present edition is most comprehensive. In clear concise language it discusses the whole regimen of the care of the patient before and after surgery.

Stuart Z. Hawkes, M.D.

Diseases of Metabolism, by Garfield G. Duncan, M.D., and 20 Contributors; 2nd Edition, 1045 pp. Philadelphia, Saunders, 1947. $12.00.

This is an excellent book and will be of particular value to the student and physician desiring a correlation of recent advances in physiology and biochemistry with clinical medicine in all its fields. In this sense the title unfortunately tells only part of the story because Dr. Duncan and his enlarged group of contributors have written a volume which is far more than an amplified section on "Diseases of Metabolism" traditional to all textbooks of medicine.

Following the pattern of the first edition, the first half of the book is devoted to the metabolism of the specific classes of foodstuffs, mineral metabolism, and a most important chapter on water and electrolyte balance in health and disease. In all of these sections the authors repeatedly show the metabolic and nutritional changes in many surgical problems and in all diseases commonly seen by the medical practitioner. A short chapter on the metabolic aspects of the blood disorders and an extensive monograph on the vitamins and avitaminoses completes this half of the volume. The second part of the book contains chapters dealing with the usual specific disorders and diseases of metabolism—xanthomatoses, gout, hyperinsulinism, melli-

turia and diabetes. Finally a new chapter in this edition on metabolism in renal diseases and a new chapter on disorders of the thyroid gland further emphasize the importance of metabolic interrelations in all medical problems.

This book can be heartily recommended and the publishers should be congratulated on the improved format as compared with Edition I. In spite of the addition of sixty pages the new edition is reduced one half inch in thickness and well over one pound in weight.

Leslie M. Townsend, M.D.

Synopsis of Physiology. By Rolland J. Main, Ph.D. Pp. 341. Illustrated. St. Louis, C. V. Mosby Co., 1946. $3.50.

This little volume is well worth reading by the student or physician preparing for examination or by one desiring a rapid and concise review of the subject. Dr. Main has eliminated all controversial material as well as that having no bearing on the physiology of the human. Furthermore, he has rearranged the material into a much more orderly and natural sequence than is usually found in the larger works. Beginning with a discussion of the physiology of the cell, the environmental adaption of cell and homeostasis of the body, the following chapters deal with circulation and tissue fluids, respiration, digestion, the nervous system, endocrines and reproduction, and finally, a miscellaneous chapter which discusses the organs of special sense, renal function, liver and liver function, tests and related material logically falling in this category. Especially deserving of praise is Dr. Main's chapter on Circulation, Tissue Fluids and Blood, which is one of the best this reviewer has read in any text of physiology.

Main's Synopsis of Physiology is a valuable addition to any practitioner's library.

N. W. G.

The Challenge of Polio; the Crusade Against Infantile Paralysis. By Roland H. Berg; introd. by Basil O'Connor, President, The National Foundation for Infantile Paralysis, Inc. 208 pp. New York, Dial Press, 1946.

This book is an excellent presentation of the evolution of our knowledge of poliomyelitis up to the present time. As the author states, it is a biography of poliomyelitis. It is written in a clear and readable manner reminiscent of Paul deKruif's writings, and should be interesting reading for both physicians and laymen who deal with infantile paralysis.

This biography begins with an interesting report of the 1916 epidemic of poliomyelitis in New York City, the first epidemic that made the nation conscious of the great disaster caused by this disease. There follows in chronological order a narration of the research work of numerous scientists in the field of poliomyelitis, such as the discovery of the virus, its transmission to laboratory animals, the isolation of the virus from the stools, etc. Interestingly told are the unsuccessful attempts by various investigators to prevent poliomyelitis by chemical means and by active immunization.

The story of President Roosevelt's affliction with this disease and his part in founding The National Foundation for Infantile Paralysis is very well presented.

The author's evaluation of Sister Kenny and her influence in stimulating interest in poliomyelitis seems clearly and fairly presented.

Also the work of the National Foundation for Infantile Paralysis in combating this disease by monetary grants for research and aid to the afflicted is told in a very enlightening manner.

The reviewer feels that this book measures up well to what it sets out to be—a biography of poliomyelitis.

Horace O. Bell, M.D.

Diabetic Care in Pictures; simplified statements with illustrations prepared for the use of the patient. By Helen Rosenthal, B.S., Frances Stern, M.A. (Honorary), and Joseph Rosenthal, M.D. PP. 150. 137 original illustrations (including 4 in color). Philadelphia, J. B. Lippincott Co., 1946. $2.00.

The authors have written and illustrated this book for the use of patients to serve "as part of the diabetic equipment, so that diabetes and its treatment may be understood and fullest cooperation given by the patient to the physician and dietitian."

To fulfill its purpose, the book has been written in simple terms, easily understood by the average layman. It is amply illustrated by charts and picture sheets, presenting drawings of various foods which the diebetic may interchange in order to break the monotony of his diet. Particularly laudable are the photographs which clearly illustrate the technical details of insulin injections, the simple urine tests and the care of the feet. Included among the photographs is the technic of the Buerger-Allen exercises which will be particularly helpful to the patient, so that this vascular treatment may be carried out correctly.

Rosenthal, Stern and Rosenthal, have had many years of experience in dealing with the diabetic patient, teaching and advising in the various details of treatment. The essential knowledge required by the diabetic is excellently compiled in this small volume; it fulfills a long felt need for a simple and instructive reference book.

The authors succeeded in their purpose: "to teach the diabetic how to carry on, so that he may lead a happy life, working and playing as normally as his family, friends and neighbors."

William Nyiri, M.D.

Gastroenterology in General Practice. Louis Penler, M.D., with the collaboration of Louis A. Held, M.D. Pp. 285 with 108 illustrations, including 20 color plates. Springfield, Ill., Charles C. Thomas, 1946. $7.50.

A large proportion of any general practitioner's patients present gastrointestinal symptoms. Because gastroenterology is such a diversified subject, it is understandable that these symptoms may receive haphazard diagnosis and treatment. Any endeavor to correct this condition is praiseworthy.

Such is the purpose of this book, and I feel that it has succeeded.

The book consists of short chapters on gastroenterologic problems ranging from pertinent topics as peptic ulcer, the irritable colon, the gall bladder disease to the more uncommon subjects as the sprue group of diseases, hyperinsulinism, and gastroscopy. Psychosomatic symtoms referable to the GI tract, case histories, history taking, and treatment of psychosomatic problems are given a prominent place in this book. Particularly commendable are the presentations of liver function, the jaundice problem and the treatment of cirrhosis of the liver. For its size, the book is amply illustrated. Included are 20 color plates, along with many other illustrations, a large proportion of them being x-ray pictures of gastrointestinal lesions, and some fifteen tables. Most texts on gastroenterology are of necessity both large and exhaustive, and are of value mainly to the specialist in the field, and as a reference. While this book has much in it culled from other authors, it has managed to touch on practically every major gastrointestinal problem. It has done so lightly, of course, but almost in every chapter with some benefit to the reader.

ANDREW J. V. KLEIN, M.D.

Experiences with Folic Acid. By Tom D. Spies, M.D. Pp. 110 Illustrated. Chicago, Year Book Publishers, Inc., 1947. $3.75.

In this book of about 100 pages Spies discusses clinical experience with folic acid at Hillman Hospital, Birmingham, Alabama, and at the University of Cincinnati School of Medicine, together with collaborative studies in Cuba and Puerto Rico undertaken to test the efficacy of folic acid in the treatment of the macrocytic anemia of sprue.

The drug was used in the treatment of over 200 cases of macrocytic anemia. Seventy-eight of these were patients with pernicious anemia and an equal number were cases of sprue. Forty-six cases of macrocytic anemia due to pellagra were treated, as were a small number in pregnancy, nutritional anemia, and cirrhosis of the liver. The unequivocal statement is made that every person with pernicious anemia, sprue, nutritional macrocytic anemia (pellagra), macrocytic anemia of pregnancy and nutritional leukopenia responded satisfactorily. Most of the patients with anemia associated with cirrhosis of the liver responded poorly, if at all.

Recognition is made of the fact that folic acid may not be adequate in preventing neurologic relapse in cases of pernicious anemia. Relationship of folic acid to liver is not clear nor is the biochemistry of its action understood. However, Spies is enthusiastic over the fact that for the first time a pure chemical of known composition, available synthetically, is effective in treating macrocytic anemias.

RICHARD A. DENO, Ph.D.

Synopsis of Pathology. By W. A. D. Anderson, M. D., F.A.C.P. 2d ed. Pp. 741; 327 text illus., 15 color plates. St. Louis, C. V. Mosby Company, 1946. $6.50.

This is the second edition of a book that is almost unique in its subject even among medical textbooks. In the preface to the first edition the author states that this synopsis was intended to fill a gap between elementary manuals on the subject and the larger reference works. It does a great deal more than this. Although not meant to be an encyclopedic work it is one of the most complete, concise texts that the reviewer has had the pleasure to read. When one considers the groping around for texts in pathology that was necessary during medical school days, in retrospect one considers the great help that this volume would have been. On the other hand, for a small reference work for a busy practice, one is amazed at the scope and completeness of the book.

Some of the outstanding features of the book are its liberal allusions to pathological physiology as well as anatomy and, in the second edition in particular, its revision to include subjects which have been emphasized during the war years, in connection with tropical diseases and war medicine.

The technical structure of the volume simply adds, in its size, printing and many illustrations, both in black and white and color, to the well organized contents. The bibliography is adequate and grouped at the end of chapter according to subject. The book is highly recommended as a basic addition to the library of the general practitioner, the internist and the pathologist.

EVERETT O. BAUMAN, M.D.

Parergon. Third ed., Mead Johnson & Company, Evansville, Ind. $5.00.

Parergon, from the Greek, means "work by the side of work" and is the title of Mead Johnson's reproductions of the works of the members of the American Physicians Art Association. The current third edition illustrates over a thousand examples of original art works by physicians. It is a handsome volume and includes photography, sculpture, water color, oils, wood carvings, weaving, tapestries, metal work, wood work, ceramics, pastels, jewelry, cabinet work, etchings, crayon, charcoal, pen drawings, painted china, clay modeling, lithographs, leather tooling and marquetry.

Judged from a nonprofessional avocation standpoint these reproductions represent amazingly fine artistic skill. Although some of the original beauty and freshness of color is lost in the transposition to black and white in the volume, reproduction is excellent and it is surprising that so much artistic skill and artistic potentiality exist in one professional group. One wonders how busy physicians can find time to become so proficient in the graphic arts. Perhaps the profession of medicine develops those traits which are the very essence of art. Mead Johnson has shown exceptional taste in layout, reproduction and cover design.

RALPH N. SHAPIRO, M.D.

Intracranial Complications of Ear, Nose and Throat Infections. Hans Brunner, M.D. Pp. 444 with 95 illustrations. Chicago, Year Book Publishers, 1946. $6.75.

Those who are not already thoroughly acquainted with this field would do well to read this book

slowly and carefully. Dr. Brunner has put into comparatively few pages a vast amount of information which covers not only his own experiences, but those of the many writers who have contributed to it. Beginning with the assumption that the reader is well informed concerning the diseases of the ear, nose and throat, Dr. Brunner carries the reader by stages into the head. These stages include the pachymeningitides, both external and internal, diseases of the dural sinuses, inflammatory diseases of the leptomeninges, and finally, the infections of the brain itself, both localized and diffused.

Each section is divided conveniently into subsections which include pathology and pathogenesis; symptomatology, treatment and prognosis. It is well that there is frequent repetition in discussing different disease entities of similar pathogenesis and symptomatology because the author's rather ponderous style of writing sometimes makes it difficult to follow what he is saying. This book will serve well as a reference for those who, in their treatment of the diseases of the ear, nose or throat, find that their patients are not responding as they should, for it will give them much to think about in considering possible complications.

Elliot Rinzler, M.D.

Clinical Methods of Neuro-ophthalmologic Examination. Alfred Kestenbaum, M.D., Pp. 384. New York, Grune & Stratton, 1946. $6.75.

This book is based on lectures delivered by the author to neurologists and ophthalmologists over a period of twenty-five years. It presents a review of the clinical methods of ophthalmologic examination useful in neurologic differential diagnosis. Anatomic data, schematized, and theoretical experiments are included only as they are required for the understanding of the methods described and the differential diagnosis. Diseases which do not require ophthalmologic signs or tests for neurologic diagnosis are omitted. These include the heredodegenerative affections of the retina, the cerebromacular degenerations, the phakomatoses, the hypertensive and sclerotic diseases of the brain and retinal vessels, and the visual disturbances in psychotic conditions.

The book is meant as a supplement to, rather than a substitute for, existing texts such as "Neuro-ophthalmology" by R. L. Rea, which discusses neurologic problems of interest to the ophthalmologists or "Neurology of the Eye, Ear, Nose and Throat" by Spiegeland Sommer, which reviews the results of clinical and experimental research.

There are thirteen chapters, grouping subjects as (I) Anatomy of the Optic Pathway, (II) Field of Vision, (III) Pathology of the Optic Nerve, (IV) Chiasmal Lesions, (V) Retro Chiasmal Lesions of the Optic Pathway. These are followed by (VI) Eye Muscle Palsy, (VII) Gaze Movement and Gaze Palsy, (VIII) Nystagmus, and (IX) Disturbance of the Symmetrical Eye movements. The remaining chapters cover such subjects as Pupil and Accommodation, Palpebral Fissure and Functional Disturbances. It concludes with a scheme for a routine Neuro-ophthalmological examination. There is an instructive glossary and an extensive bibliography.

The subject of field of vision is well discussed. The methods of perimetry are described, including those of the clinic with the various instruments which permit precise measurements of defects, and those which are less perfect but more easily applicable and useful out of the hospital or with patients who are unable to cooperate fully. Defects are described and listed with probable causative lesions.

The chapter on gaze movement and gaze palsy is of especial interest. The position of a patient's eyes, and his ability or inability to move them, often indicates and even locates a central nervous system lesion. A description of a number of gaze movement defects, with their significance, is given. The presentation of nystagmus, both spontaneous and induced, permits a practical understanding of this complex subject, and it should be of useful clinical application. The material is well organized. It is clearly written—indeed in many places the clarity may deceive the reader into believing the subject is very simple. Explanations are to the point. There is a great deal of important information packed into a small space.

This book should prove an excellent text for the student of ophthalmology or neurology as well as a reference work for the practitioner in those specialities.

The Diagnosis and Treatment of Bronchial Asthma. By Leslie N. Gay, Ph.B., M.D. Pp. 334. Baltimore, The Williams and Wilkins Company, 1946. $5.00.

In this study of bronchial asthma the subject is presented so that the doctor interested in allergy may avail himself of a comprehensive and elementary description of this disease.

The author's experience appears to be the most important source of information and therefore much that is of original value may be gleaned.

He believes that, in general, inhaled allergens are more important in the etiology of asthma than ingested factors. It must be kept in mind that there are many workers who would differ widely with this opinion and who ascribe a large measure of importance to foods. As with other authors of texts and current journal articles he gives upper respiratory infection and emotional factors a large measure of importance.

The chapter of pathology is most detailed and complete, with autopsy reports giving excellent and vivid examples of the classical pathology described.

The last chapter includes all known methods of treatment presented in a lucid and readable manner and it is here particularly that Dr. Gay's long and inclusive experience with asthma is most contributory to the reader.

General practitioners who practice allergy will find that this book is of clinical and theoretic value. Specialists in allergy will find many unusual points of interest that represent years of keen observation by a sincere, acute observer.

Louise Fischer, M.D.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **October, 1947** **No. 10**

A WIDE segment of our adult male population had chest X-rays at induction into the Armed Forces. Unsuspected abnormalities of the lungs, mediastinum, thoracic cage and heart were disclosed, many in a presymptomatic stage. The most fruitful result of these surveys, however, has been the discovery of early pulmonary tuberculosis. In this age group, carcinoma of the lung was rarely encountered, but in the present surveys of industrial groups one of the lesions coming to light is asymptomatic circumscribed carcinoma of the lung.

CARCINOMA SIMULATING PULMONARY TUBERCULOSIS

The roentgen appearance of a circumscribed pulmonary carcinoma may be simulated by a solitary noncavity tuberculous focus. In any large series of pneumonectomies for bronchial carcinoma, there will be cases in which lungs containing an isolated, large, tuberculous nodule have been excised. In the two cases reported here, the situation was reversed. These patients were treated for pulmonary tuberculosis for many months before the neoplastic nature of the lesions was recognized.

Case 1: A 61-year-old man had a roentgen film of his chest made in an industrial survey in December, 1943. He was told that he had a tuberculous lesion and was referred to his family physician. After further X-ray study, the physician agreed with this diagnosis. The film showed a faint amorphous density, about 2 cm. in diameter, in the subapical portion of the right upper lobe. The mesial and lower borders of the density appeared somewhat rounded and it faded off laterally into several streaks. A lateral film showed that the lesion was located in the posterior portion of the lobe, a predilection site for early tuberculosis. A chest film made routinely three years previous had disclosed normal lung fields.

He was sent to a tuberculosis institution but no tubercle bacilli could be found in specimens of gastric contents. Since he remained free of symptoms and the lesion appeared unchanged, he was discharged after eight weeks. Four months later, the lesion appeared denser and was 3 cm. in diameter. One month later there was further increase in the size and density of the lesion. The borders were sharper and the diameter measured about 4 cm. Another physician then thought that the patient had a circumscribed pulmonary carcinoma.

On admission to the hospital the patient was found to be well nourished. Physical examination showed no abnormality aside from slight clubbing of the fingers. Tubercle bacilli could not be demonstrated and bronchoscopy did not reveal abnormal findings.

The chest was explored on July 12, 1944. A walnut-shaped mass was palpated in the right upper lobe which was removed, together with the adherent right middle lobe and the regional lymph nodes. On section, the tumor was found sharply circumscribed and proved to be an epidermoid carcinoma. The lymph nodes showed no tumor cells. There was no evidence of a tuberculous lesion. There was no recurrence of the tumor two years after operation.

Circumstances leading to the correct diagnosis in the second case parallel those of the first.

Case 2: A woman of 43 had an industrial chest survey film made in April, 1944. A right upper lobe lesion was found and, after study, the patient was told that she had arrested pulmonary tuberculosis. There were no pulmonary symptoms. The shadow was faint, appeared oval-shaped and measured about 2 cm. in diameter. Its outer border was hazy and several streaks extended from it peripherally. Since tubercle bacilli could not be

demonstrated in the body secretions, the patient was allowed to return to work.

Six months later a film revealed a few moth-eaten areas of lesser density within the shadow, but the size was unchanged. Three months later, the shadow was larger and stood out more sharply from the surrounding lung parenchyma. Eight months later the shadow measured 4 cm. in diameter. Her physicians decided that she had active tuberculosis and recommended sanatorium care. She consulted another physician who thought that her film series indicated the presence of a slow-growing circumscribed neoplasm.

On admission to the hospital, the patient had no complaints and physical examination disclosed no abnormalities. No other primary site could be found nor was there any evidence of distant metastatic lesions. A posterior-anterior view of the chest showed a dense oval shadow in the right upper lobe. The lateral chest film showed the lesion to be located in the posterior portion of the upper lobe and sectional radiography disclosed several irregular areas of decreased density within it.

The first attempt to explore the chest was abandoned because the patient went into severe shock. At the second operation two weeks later a partial lobectomy of the portion of the lobe containing the tumor was performed. No involvement of the lymph nodes, pleura or chest wall was noted.

Grossly, the specimen showed a well circumscribed oval neoplasm; in its center were several small areas of necrosis; it was an adenocarcinoma. A small bronchopulmonary lymph node showed no tumor cells. No tuberculous lesions could be found.

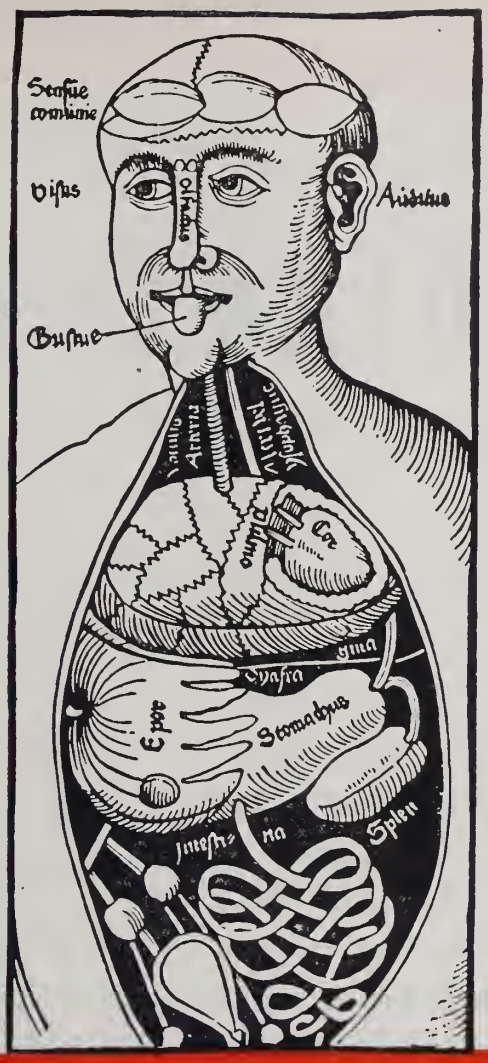
These two cases point up some of the difficulties in differentiating a slow-growing circumscribed neoplasm of the lung and a solitary tuberculous focus, particularly when the lesion is situated in the upper lobes. A proper evaluation of the alterations in the appearance of the lesion on successive films was crucial in both these cases, since neither of the patients had any symptoms. Circumscribed bronchial carcinoma may be silent for a prolonged period and, in this respect, behaves like many cases of early pulmonary tuberculosis.

At the present time, physicians are aware that pulmonary tuberculosis produces few symptoms and signs at its onset and that the diagnosis must be made in this stage if the chances of recovery are to be maximum. This is no less true of the circumscribed varieties of bronchial carcinoma. Mass surveys and routine chest roentgenography are becoming the important methods by which operable pulmonary cancers are discovered. The two cases reported here were mistaken for pulmonary tuberculosis for seven and sixteen months, respectively, before they were admitted to a hospital for surgery.

Carcinoma Simulating Pulmonary Tuberculosis, Louis E. Siltzbach, M.D., The American Review of Tuberculosis, February, 1947.

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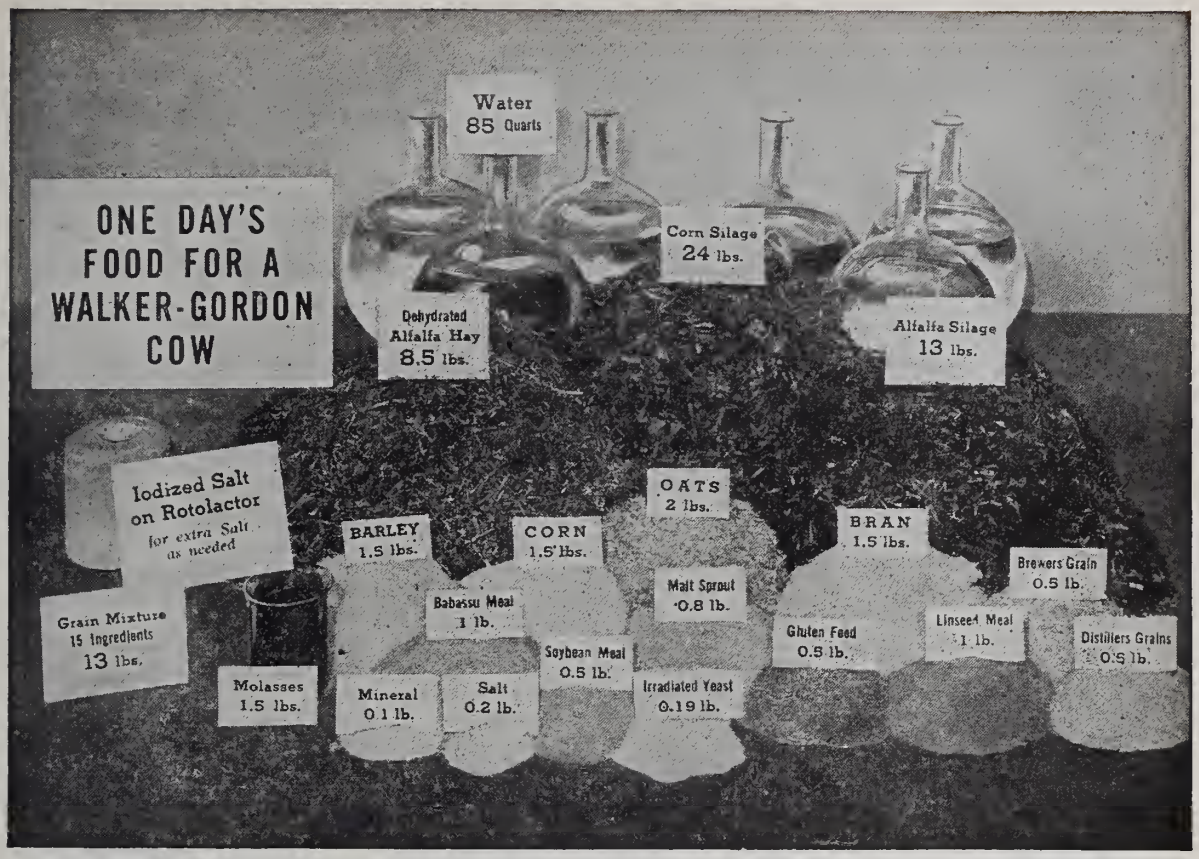
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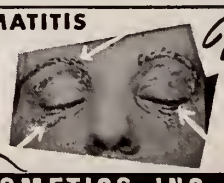
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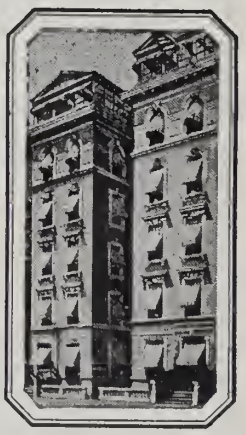
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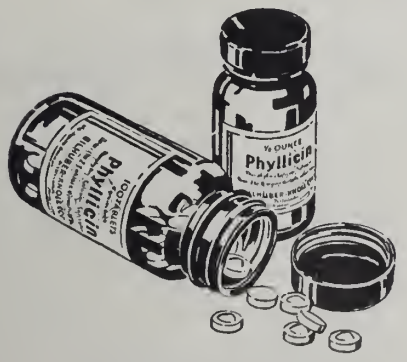


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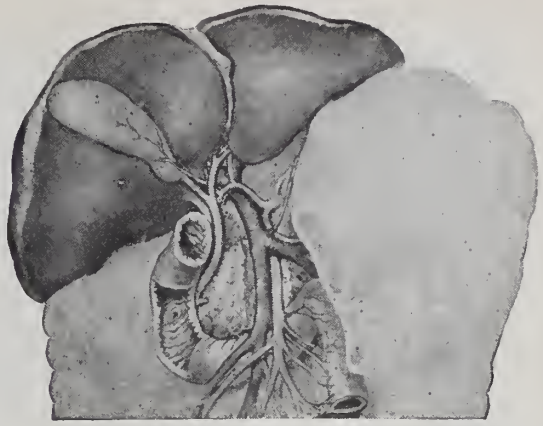
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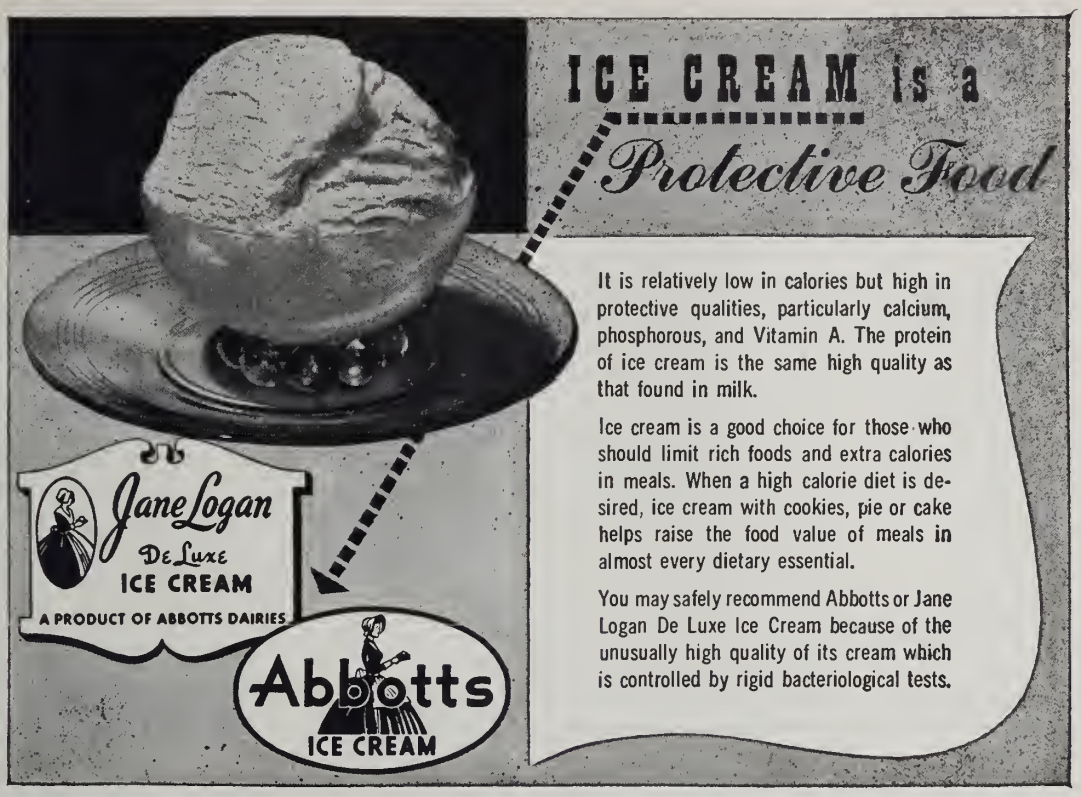
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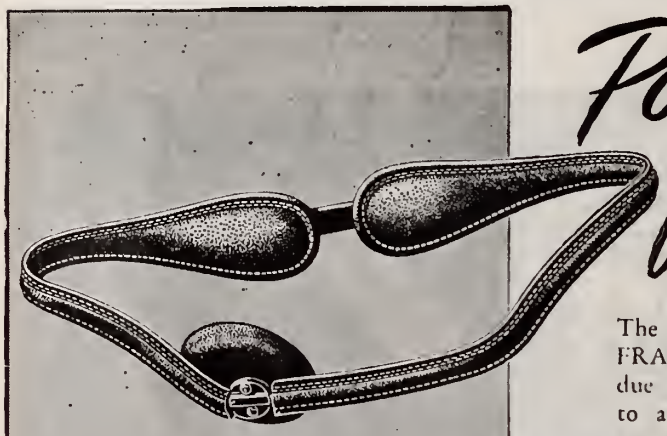

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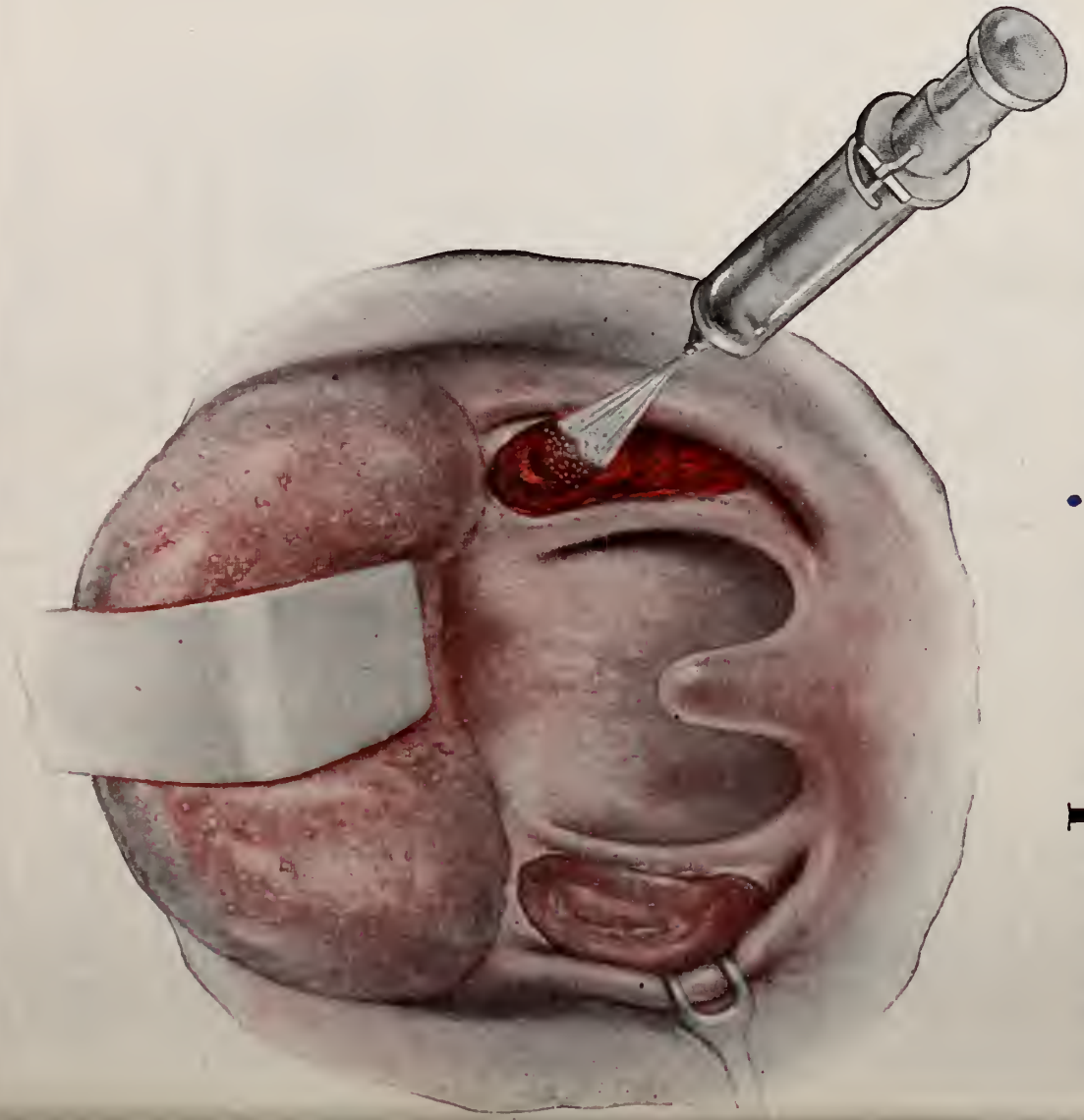
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Room 1302, 28 W. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 230

American Cancer Society, New Jersey Division, Inc.

L. S. Snegireff, M.D., *Medical Director*
790 Broad St., Newark 2, N. J.
Tel. MItchell 2-4288

N. J. State Crippled Children's Commission

Mrs. Joseph G. Buch, *Executive Director*
Room 732, 143 E. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 8174

N. J. Rehabilitation Commission

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Room 735, 143 E. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 527

N. J. State Board of Children's Guardians

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163 W. Hanover St., Trenton 8, N. J.
Tel. 2-2131, Ext. 308

N. J. State Board of Medical Examiners

Earl S. Hallinger, M.D., *Secretary*
Room 1101, 28 W. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 272

N. J. State Department of Motor Vehicles

Arthur W. Magee, *Commissioner*
State House Office Building, Trenton 8, N. J.
Tel. 2-2131, Ext. 208

N. J. State Department of Health

J. Lynn Mahaffey, M.D., *Director of Health*
Room 232, State House, Trenton 8, N. J.
Tel. 2-2131, Ext. 541

N. J. State Nurses Association

Miss Wilkie Hughes, R.N., *General Secretary*
Room 1112, 17 Academy St., Newark 2, N. J.
Tel. MArket 3-6361

N. J. Hospital Association

F. Harold Johnston, *Executive Secretary*
180 Somerset St., New Brunswick, N. J.
Tel. 2-8200

N. J. Pharmaceutical Association

John J. Debus, *Executive Secretary*
Room 318, 28 W. State St., Trenton 8, N. J.
Tel. 5596

N. J. State Dental Society

John G. Carr, D.D.S., *Executive Secretary*
223 E. Hanover St., Trenton 8, N. J.
Tel. 5084

N. J. Health Officers' Association

William C. Blake, *Secretary*
Thomson Hall, Princeton, N. J.
Tel. 1005

N. J. Health and Sanitary Association

John Hall, *Executive Secretary*
3 Morris St., Freehold, N. J.
Tel. 8-0410 M

STANDING COMMITTEES

Meetings at the call of the Chairmen

Finance and Budget

David B. Allman, *Chairman* (1953) .....Atlantic City
Herschel Pettit (1948) .....Ocean City
William F. Costello (1949) .....Dover
Luke A. Mulligan (1950) .....Leonia
L. Samuel Sica (1951) .....Trenton
Anthony J. Conty (1952) .....Union City
George J. Young, *Ex-Officio* .....Morristown

Medical Defense and Insurance

J. Wallace Hurff, *Chairman* (1950) .....Newark
Robert L. McKiernan (1948) .....New Brunswick
Wayne W. Hall (1949) .....Paterson
Arthur J. Ganley (1949) .....East Orange
George T. Tracy (1950) .....Beverly

Publication

Henry C. Barkhorn, *Chairman* (1948) .....Newark
Lewis W. Brown (1949) .....Newark
J. Lawrence Evans (1950) .....Woodcliff
Royal A. Schaaf, *Ex-Officio* .....Newark
Earl LeRoy Wood, *Ex-Officio* .....Newark

Scientific Work

First District—John W. Gray (1949) .....Newark
Second District—Wm. W. Mayer, *Chm.* (1950)...Jersey City
Third District—Patrick H. Corrigan (1951).....Trenton
Fourth District—S. Emlen Stokes (1952).....Moorestown
Fifth District—Harold S. Davidson (1948)....Atlantic City
George Ginsberg (1948) .....Hoboken
John H. Rowland (1949) .....New Brunswick

Honorary Membership

E. Zeh Hawkes, *Chairman* (1949) .....Newark
Spencer T. Snedecor (1948) .....Hackensack
Ralph K. Hollinshed (1950) .....Westville

Woman's Auxiliary

William E. Dodd, *Chairman* (1950) .....Beach Haven
Hammell P. Shipps (1948) .....Delanco
L. Samuel Sica (1948) .....Trenton
Ily R. Beir (1949) .....Atlantic City
Samuel Blaugrund (1950) .....Trenton

Post-Graduate Education

Henry B. Decker, *Chairman* (1949) .....Camden
Albert W. Pigott (1948) .....Skillman
Samuel A. Cosgrove (1949) .....Jersey City
Ernest F. Purcell (1950) .....Trenton
Stuart Z. Hawkes (1950) .....Newark
William F. Costello .....Dover

Annual Meeting

Harrold A. Murray, *Chairman* (1949) .....Newark
John W. Gray (1948) .....Newark
Johannes F. Pessel (1949) .....Trenton
Clarence L. Andrews (1950) .....Atlantic City
Francis M. Clarke (1950) .....New Brunswick
Asher Yaguda .....Newark

Scientific Program

Francis M. Clarke, *Chairman* .....New Brunswick
Charles D. Driscoll .....West Collingswood
Clymont MacArthur .....Newark

Scientific Exhibit

Asher Yaguda, *Chairman* .....Newark
William W. Hersohn .....Atlantic City
Frank W. Konzelmann .....Absecon
Albert H. Shafer .....Camden
John L. Olpp .....Englewood
John H. Rowland .....New Brunswick
Manfred Kraemer .....Newark

WELFARE COMMITTEE

Meetings in Trenton at 2:00 P. M. on September 14, December 14 and March 7

VINCENT P. BUTLER, *Chairman* ..... Jersey City
ROYAL A. SCHAAF, *Ex-Officio* ..... Newark
EARL LEROY WOOD, *Ex-Officio* ..... Newark
DAVID B. ALLMAN (Atlantic County) ..... Atlantic City
EDWARD H. GUION ..... Pleasantville
D. WARD SCANLAN ..... Atlantic City
JOHN L. OLPP (Bergen County) ..... Englewood
HARLAND C. ESSERTIER ..... Ridgewood
PAUL R. SPARKS (Burlington County) ..... Burlington
R. WINFIELD BETTS ..... Medford
WILLIAM E. BRAY ..... Pemberton
ARTHUR G. PRATT (Camden County) ..... Camden
H. WESLEY JACK ..... Camden
EDWARD A. Y. SCHELLENGER ..... Camden
MILLARD C. CRYDER (Cape May) ..... Cape May Court House
ALDRICH C. CROWE ..... Ocean City
SAMUEL B. HUGHES ..... Wildwood
CHARLES CUNNINGHAM, JR. (Cumberland County) ... Vineland
ALBERT B. KUMP ..... Bridgeton
MARCUS H. GREIFINGER (Essex County) ..... Newark
THOMAS W. HARVEY ..... Orange
HARROLD A. MURRAY ..... Newark
J. WALLACE HURFF ..... Newark
HARRY N. COMANDO ..... Newark
WENDELL J. BURKETT (Gloucester County) ..... Pitman
CHESTER I. ULMER ..... Gibbstown
J. LAWRENCE EVANS (Hudson County) ..... Woodcliff
BERTHOLD S. POLLAK ..... Jersey City
HUGH H. TYNDALL ..... Weehawken
PHILIP W. BAKER (Hunterdon County) ..... High Bridge
BARCLAY S. FUHRMANN ..... Flemington
SAMUEL BLAUGRUND (Mercer County) ..... Trenton
L. SAMUEL SICA ..... Trenton
JOHN L. WIKOFF ..... Trenton
RALPH J. FAULKINGHAM (Middlesex County) .. New Brunswick
JOHN H. ROWLAND ..... New Brunswick
C. BYRON BLAISDELL (Monmouth County) ..... Long Branch
STANLEY NICHOLS ..... Long Branch
LOUIS F. ALBRIGHT ..... Spring Lake
GEORGE B. EMORY, JR. (Morris County) ..... Morristown
SALVATORE GIORDANO ..... Morristown
GEORGE L. NICOLL ..... Succasunna
RAYMOND A. TAYLOR (Ocean County) ..... Lakewood
CARMINE L. PECORA ..... Toms River
ADOLPH TOWBIN ..... Lakewood
HOMER H. CHERRY (Passaic County) ..... Paterson
H. HALE HOLLINGSWORTH ..... Clifton
MORRIS JOSEPH ..... Passaic
JOSEPH R. JEHL ..... Clifton
HARRY F. SUTER (Salem County) ..... Penns Grove
FRANK L. PERRY ..... Woodstown
WILLIAM J. ALBRECHT (Somerset County) ..... Somerville
LEWIS C. FRITTS ..... Somerville
JAMES H. SPENCER, JR. (Sussex County) ..... Newton
KATHERINE E. STEWART ..... Ogdensburg
J. MALLORY CARLISLE (Union County) ..... Westfield
FREDERICK W. LATHROP ..... Plainfield
HERSCHEL S. MURPHY ..... Roselle
THOMAS J. WALSH ..... Elizabeth
WATSON B. MORRIS ..... Springfield
RALPH M. L. BUCHANAN (Warren County) ..... Phillipsburg
WILLIAM H. VARNEY ..... Washington

Consultants

MR. JOHN J. DEBUS (Pharmaceutical Association) ... Trenton
EMIL FRANKEL, Ph.D. (Institutions and Agencies) .... Trenton
EARL S. HALLINGER (Medical Examiners) ..... Trenton
MR. WILLIAM H. MACDONALD (Health) ..... Trenton
FREDERIC J. QUIGLEY (Legislation) ..... Union City

SUBCOMMITTEES TO THE WELFARE COMMITTEE

Meetings in Trenton at 11:00 A. M. on September 14, December 14 and March 7

Legislation

BERTHOLD S. POLLAK, *Chairman* ..... Jersey City
WENDELL J. BURKETT, *Vice-Chairman* ..... Pitman
J. WALLACE HURFF ..... Newark
THOMAS J. WALSH ..... Elizabeth
CHARLES H. MITCHELL ..... Trenton
FREDERICK S. TABER ..... New Brunswick
SAMUEL ALEXANDER ..... Park Ridge
FREDERIC J. QUIGLEY, *Executive Secretary* ..... Union City

Medical Practice

HERSCHEL S. MURPHY, *Chairman* ..... Roselle
J. MALLORY CARLISLE ..... Westfield
ANDREW C. RUOFF ..... Union City
WILLIAM K. HARRYMAN ..... Hackensack
H. WESLEY JACK ..... Camden
CHESTER I. ULMER ..... Gibbstown
GEORGE BLACKBURNE ..... Newark
ASHER YAGUDA ..... Newark
HAROLD G. WALKER ..... Wyckoff
W. JAMES MARQUIS ..... East Orange
BROR S. TROEDSSON ..... Orange
EARL H. SNAVELY ..... Newark

Public Health

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HARROLD A. MURRAY, *Vice-Chairman* ..... Newark
ABRAHAM E. JAFFIN ..... Jersey City
ROBERT A. MACKENZIE ..... Asbury Park
ELBERT S. SHERMAN ..... Newark
HENRY A. COTTON, JR. ..... Trenton
HAROLD F. TIDWELL ..... West New York
ROBERT L. MCKIERNAN ..... New Brunswick
CHRISTIAN P. SEGARD ..... Leonia
WILLIAM O. WUESTER ..... Hillside
H. EUGENE READING ..... Paterson
S. WILLIAM KALB ..... Newark
JEROME KAUFMAN ..... Newark
RALPH K. HOLLINSHED ..... Westville
STANLEY NICHOLS ..... Long Branch
C. BYRON BLAISDELL ..... Long Branch
JAMES O. HILL ..... Newark

Consultants

DANIEL BERGSMA (Health) ..... Trenton
JULIUS LEVY (Maternal and Child Health) ..... Trenton
MR. WILLIAM H. MACDONALD (Health) ..... Trenton
EMIL FRANKEL, Ph.D. (Institutions and Agencies) .. Trenton
MR. JOHN J. DEBUS (Pharmaceutical) ..... Trenton
MRS. STEPHEN W. WATERBURY (Welfare Council) ... Hillside
MARY M. MUCKLEY (Nurses) ..... Fairlawn
ARTHUR B. PEACOCK (Board of Health) ..... Moorestown

Public Relations

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NORMAN M. SCOTT ..... Newark
HENRY A. DAVIDSON ..... Flemington

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Meetings at the call of the Chairmen

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RALPH K. HOLLINSHED, *Chairman* ..... Westville
JOSEPH W. GARDAM ..... Newark
EDWARD C. KLEIN, JR. ..... Newark

Cancer Control

WILLIAM O. WUESTER, *Chairman* ..... Hillside
OTTO R. HOLTERS ..... Asbury Park
LEONID S. SNEGIREFF ..... Trenton
THOMAS B. LEE ..... Camden
JOSEPH I. ECHIKSON ..... Newark
W. JAMES MARQUIS ..... East Orange
H. WESLEY JACK ..... Camden
JOSEPH H. KLER ..... New Brunswick
PETER J. DEBELL ..... Passaic
JOHN L. OLPP ..... Englewood

Consultants

EMIL FRANKEL, Ph.D. (Institutions and Agencies) ... Trenton
RAYMOND V. BROKAW (Health) ..... Trenton

Cardio-Vascular Diseases

Jerome G. Kaufman, *Chairman* ..... Newark
Harvey M. Ewing ..... Montclair
Clarence L. Andrews ..... Atlantic City
Paul A. Kennedy ..... Englewood
Thomas J. White ..... Jersey City
LeRoy W. Black ..... Rutherford
Evelyn Holt ..... Summit
Nicholas A. Antonius ..... Newark
Frank J. Altschul ..... Long Branch
Patrick H. Corrigan ..... Trenton
Julian Cohen ..... Paterson
Norman Reitman ..... New Brunswick
Harvey Nussbaum ..... Newark
Louis F. Albright ..... Spring Lake

Child Health

Stanley Nichols, *Chairman* ..... Long Branch
Harrold A. Murray ..... Newark
Ernest G. Hummel ..... Camden
Walter B. Stewart ..... Atlantic City
George M. Levitas ..... Westwood
L. Charles Rosenberg ..... Newark
Geoffrey W. Esty ..... Westfield
Chester R. Brown ..... Arlington
Harold F. Tidwell ..... West New York
Edward P. Duffy ..... Nutley

Consultants

The New Jersey Fellows of the American Academy of Pediatrics

Conservation of Vision and Hearing

Elbert S. Sherman, *Chairman* ..... Newark
Halvor L. Harley ..... Atlantic City
Reinold W. terKuile ..... Ridgewood
James S. Shipman ..... Camden
Joseph H. Kler ..... New Brunswick
Jacob J. Mann ..... Perth Amboy
Charles H. Schlichter ..... Elizabeth
James A. Fisher ..... Asbury Park
Irvin Levy ..... Trenton

Consultant

Wilson G. Guthrie (Education) ..... Trenton

Crippled Children

H. Eugene Reading, *Chairman* ..... Paterson
Frederick G. Dilger ..... Hackensack
Leopold Szerlip ..... Newark
Toufick Nicola ..... Montclair
Paul J. Finegan ..... Trenton
David B. Allman ..... Atlantic City
John J. Flanagan ..... Newark
Elmer P. Weigel ..... Plainfield
Henry H. Kessler ..... Newark

Maternal Welfare

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Alfred Meurlin ..... East Orange
J. Carlisle Brown ..... Atlantic City
Howard C. Curtis ..... Moorestown
Samuel A. Cosgrove ..... Jersey City
Herschel S. Murphy ..... Roselle
Alfred D. Summers ..... Princeton
Gerald W. Hayes ..... East Orange
Richard F. Tomec ..... Montclair
John D. Preece ..... Trenton
Edward N. Comando ..... Newark
Joseph E. Mott ..... Paterson

Consultant

Julius Levy (Maternal and Child Health) ..... Trenton

Mental Hygiene

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Theodore Robie ..... East Orange
George S. Stevenson ..... Red Bank
Lewis H. Loeser ..... Newark
Luman H. Tenney ..... Princeton
Charles C. Graves, Jr. ..... Marlboro
Henry A. Davidson ..... Flemington
Roland J. Lynch ..... Secaucus
Harrison F. English ..... Trenton

Consultants

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Leonard Scheinman (Veterans Administration) ..... Newark

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Clarence B. Whims ..... Ventnor
James T. Dodge ..... Trenton
Charles F. Church ..... New Brunswick
Vincent P. DelDuca ..... Camden
Stephen Sewell ..... Spring Lake

Tropical Disease

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Frank J. Altschul ..... Long Branch
Arturo R. Casilli ..... Elizabeth

Consultants

Edward Henderson (Pathologist) ..... Bloomfield
Redginal Hewitt (Parasitologist) ..... Pearl River, N. Y.
Leslie A. Stauber (Zoologist) ..... New Brunswick

School Health

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Vincent P. DelDuca ..... Camden
Eli Rubenstein ..... Bayonne
Chester R. Brown ..... Arlington

Tuberculosis

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Harold S. Hatch ..... Morristown
Rufus R. Little ..... Oradell
Marcus W. Newcomb ..... Browns Mills
Charles I. Silk ..... Perth Amboy
Joseph A. Smith ..... Glen Gardner
Martin H. Collier ..... Camden
A. Joseph Hughes ..... Camden
Homer H. Cherry ..... Paterson

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Maurice H. Axilrod ..... Atlantic City
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Isidore Pincus ..... Newark
Baxter A. Livengood ..... Woodbury
H. Donald Cowlbeck ..... Trenton
Thomas M. Morris ..... Plainfield
John C. Clark ..... Asbury Park

ADVISORY COMMITTEES TO THE SUBCOMMITTEE ON MEDICAL PRACTICE

Meetings at the call of the Chairmen

Anesthesiology

Harold G. Walker, *Chairman* ..... Wyckoff
Archer C. Bush ..... Montclair
Leo J. Fitzpatrick ..... Englewood
Nicholas Palma ..... Paterson
Lester W. Netz ..... Hackensack
Edward T. Lawless ..... Bloomfield

Contract Practice

Andrew C. Ruoff, *Chairman* ..... Union City
George H. Van Emburgh ..... Arlington
Matthew F. Urbanski ..... Perth Amboy
Arthur G. Pratt ..... Camden

Hospital Relationships

Earl H. Snavely, *Chairman* ..... Newark
George O'Hanlon ..... Jersey City
J. Harris Underwood ..... Woodbury
J. Lawrence Evans ..... Woodcliff

Industrial Health and Hygiene

J. Mallory Carlisle, *Chairman* ..... Westfield
Arthur F. Mangelsdorff ..... Plainfield
Edgar E. Evans ..... Penns Grove
Augustus Gibson ..... Mendham
George A. Paul ..... Irvington

Medical Care of the Indigent

George Blackburne, *Chairman* ..... Newark
J. Wallace Hurff ..... Newark
Benjamin A. Furman ..... Newark
Paul H. Hosp ..... Newark
Harold C. Cox ..... Hightstown

Consultant

Norman M. Scott ..... Newark

Laboratory Medicine

ASHER YAGUDA, *Chairman* ..... Newark
A. HOBSON DAVIS ..... Paterson
SAMUEL A. GOLDBERG ..... Newark
FRANK W. KONZELMANN ..... Atlantic City
CARLOS A. PONS ..... Asbury Park

Nursing and Nursing Education

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HOMER I. SILVERS ..... Ventnor
WILLIAM T. READ, JR. ..... Camden

Pharmaceutical Problems

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ALBERT B. KUMP ..... Bridgeton
JOHN L. VARRIANO ..... Jersey City
ANTHONY J. DIIELSI ..... Camden
LOUIS SCHNEIDER ..... Newark

Physical Medicine

BROR S. TROEDSSON, *Chairman* ..... Orange
MICHAEL J. O'CONNOR ..... Newark
JOSEPH F. A. RUBACKY ..... Passaic
ELMER J. ELIAS ..... Trenton

Radiology

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JOHN L. OLPP ..... Englewood
HARRY J. PERLBERG ..... Jersey City
PHILIP S. AVERY ..... Bound Brook
HARRY R. BRINDLE ..... Asbury Park
RAPHAEL POMERANZ ..... Newark

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ALBERT W. CLOUD ..... Englewood
H. BURTON WALKER ..... Vineland
MARCUS H. GREIFINGER ..... Newark
ROBERT H. HILL ..... Newark

Consultant

HENRY A. BRODKIN (Rehabilitation) ..... Newark

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STEWART F. ALEXANDER ..... Park Ridge
STUART Z. HAWKES ..... Newark
WILLIAM G. HERRMAN ..... Asbury Park
ANDREW F. McBRIDE, JR. ..... Paterson
WALTER F. PHELAN ..... Elizabeth

Study of Medical Care

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FREDERIC J. QUIGLEY ..... Union City
HARROLD A. MURRAY ..... Newark
SAMUEL BLAUGRUND ..... Trenton
SAMUEL ALEXANDER ..... Park Ridge
C. BYRON BLAISDELL ..... Long Branch
VINCENT P. BUTLER ..... Jersey City

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WILLIAM G. HERRMAN ..... Asbury Park
EARL LEROY WOOD ..... Newark

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OCEAN	Norman F. Szold, Lakewood	Harvey Rinzler, Toms River Tel. 8-0408	B. W. Gartlan, Toms River
PASSAIC	Leon E. DeYoe, Paterson	John E. Leach, Fair Lawn Tel. Lambert 3-6686	Joseph E. Mott, Paterson
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UNION	Stanton H. Davis, Plainfield	Edward G. Bourns, Westfield Tel. 2-2285-J	E. M. Satulsky, Elizabeth
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MEAT

And Protein Deficiency

While protein deficiencies per se are difficult to recognize in their incipiency, conditions which lead to negative nitrogen balance are well known. The presence of any of the following states which characteristically exert an adverse influence on nitrogen balance, calls for immediate measures to prevent serious protein depletion:

1. Diseases of the digestive organs, which impair proper digestion and absorption.
2. Wasting diseases, infections and thyrotoxicosis, which increase protein breakdown and need far above normal levels.
3. Hemorrhage, burns, and chronic exudative processes, causing excessive loss of protein.

A high protein diet, whenever possible, is considered to be the most effective method of protein administration in the prevention and correction of protein deficiencies.

Meat, which readily is eaten two or more times daily, is an excellent component of the high protein diet. Meat is an outstanding source of protein for the following reasons. The protein of meat is biologically complete, capable of satisfying the body's protein needs. The percentage of protein contained in meat makes it one of man's most important protein foods. And, all meat is highly digestible—96 to 98 per cent—an important consideration especially in the presence of disease.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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PRIVINE

(brand of nophazoline) Trade Mark Reg. U. S. Pat. Off.

PROMPT, LONG-LASTING VASOCONSTRICTION

Privine hydrochloride promptly shrinks congested nasal mucous membranes, inducing vasoconstriction which lasts for several hours. Only three drops in each nostril t.i.d. are usually sufficient. Other important qualities which have gained for Privine its prominent position in the field of nasal therapy are: pH of 6.2 to 6.3; aqueous, isotonic solution; non-injurious to nasal mucous membrane; minimal side reactions. Furnished as solution in dilutions of 0.05 and 0.1 per cent, and as jelly in 0.05 per cent concentration.

Accepted for inclusion in 

New and Non-Official Remedies

CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT, NEW JERSEY

2/1217

PYRIBENZAMINE

(brand of tripelennamine) Trade Mark Reg. U. S. Pat. Off.

NOW READILY AVAILABLE

Whenever antihistaminics



are indicated

Atapic dermatitis—flexural eczema. Pyribenzamine relieves itching in acute and chranic eczema in a substantial number af cases.

In its comparatively low frequency of side reactions, permitting large doses where needed, Pyribenzamine hydrochloride offers important therapeutic advantages whenever antihistaminic medication is indicated. This new product of Ciba research is characterized by its capacity to counteract many of the effects of histamine. It prevents and controls certain allergic manifestations believed to be caused wholly or in part by release of histamine. Its action is palliative, not curative.

In the suggested list of indications below, Pyribenzamine has been used advantageously by many clinical investigators.

Chronic Urticaria • Acute Urticaria • Dermographism • Angioneurotic Edema
Hay Fever • Vasomotor Rhinitis • Atopic Dermatitis • Serum Reactions • Asthma
Urticarial Food and Drug Reactions

TABLETS: 50 mg., scored for divided dosage. Bottles of 50 and 500.
ELIXIR: 20 mg. per 4 cc. (teaspoonful). Sweetened and flavored. Pints.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

CIBA PHARMACEUTICAL PRODUCTS, INC.

SUMMIT, NEW JERSEY

No. 208 in the "See Your Doctor" series

. . . published in behalf of the medical profession

To an audience of over 23 million people, in LIFE and other national magazines, Parke-Davis presents the message shown below.

A reproduction in full color will be sent on request. Write to Parke, Davis & Company, Detroit 32, Michigan.

Some things you should know about **your family doctor**

No. 208 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



IF YOUR family doctor were asked to value his own services, he would probably pass over the number of lives he saves in times of crisis.

He would be likely to think first of the day-to-day help he gives to the hundreds of people who look to him as a medical advisor and friend.

For your family doctor—and every family doctor—is primarily concerned with *people*. He knows each of his patients as an individual human being, whose physical make-up and reactions, whose personal problems are never quite like anyone else's.

Following you through the years, he gains a unique understanding of you as a person.

He knows whether you have, normally, a fast pulse or a slow one; whether you run a high temperature on slight provocation, or only in serious illness.

He knows what strains your job places on you; what your past problems have been; what to look out for as a danger signal in the future.

This knowledge, which deepens every time he sees you, serves him well when you are ill. For he can judge the importance of your symptoms against the background of your individual history.

With this knowledge he can also help you *avoid* many kinds of illness. By detecting and taking care of minor ailments early, he can often keep them from becoming serious.

By his years of training and experience, and his continuing study of advances in medical science, your family doctor is qualified to deal with the many and varied medical problems that arise in his daily practice.

Give him your complete confidence at all times and follow his recommendations.

Should he suggest a consultation with a fellow physician, or advise you to go to the hospital, you can be sure that such advice is based on his broad general knowledge of medicine plus his familiarity with your particular case.

SEE YOUR DOCTOR. Make him a part of your family's life. His continuing supervision is your best guarantee that your children will grow up well and strong, and that you will live a long and healthy life.

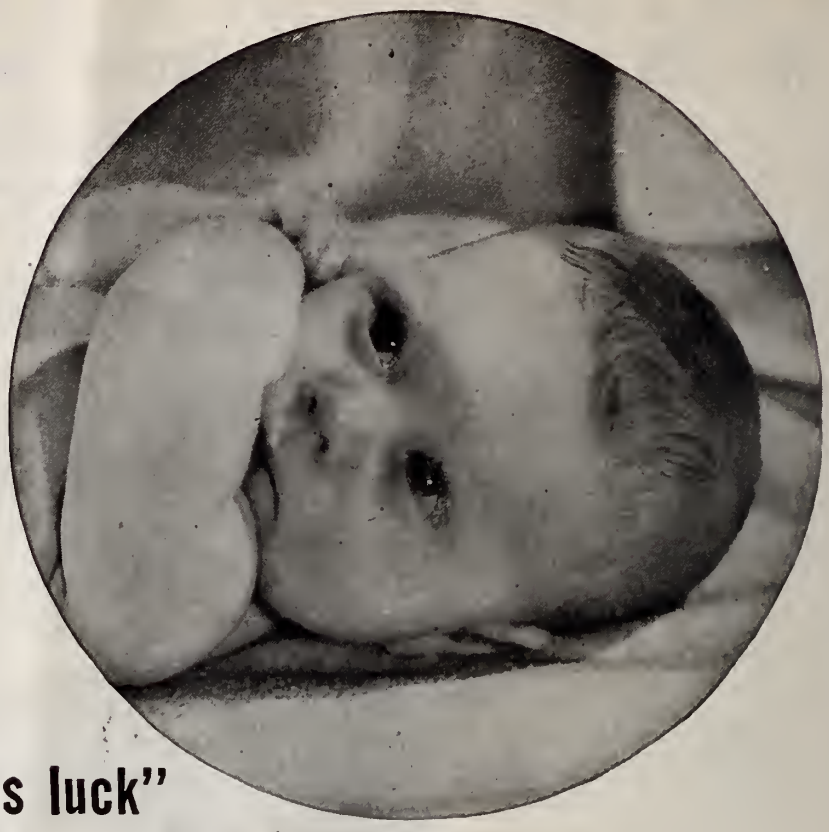
And through the years, turn to him whenever you are troubled by a problem concerning your health. His wisdom and friendly understanding make him the best counselor anyone could hope to find.

Makers of medicines prescribed by physicians

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PARKE, DAVIS & CO.

Research and Manufacturing Laboratories, Detroit 32, Mich.



"Beginner's luck" isn't always good

The good luck so often attributed to beginners can't be counted on in infancy. Here the "beginners" often meet insurmountable obstacles which have raised the proportion of infant deaths within the first 30 days to 62.1% of the total infant mortality.* During this hazardous first month proper selection of the first formula is therefore of vital importance.

'Dexin' has proved an excellent "first carbohydrate" because of its high dextrin content. It (1) resists fermentation by the usual intestinal organisms; (2) tends to hold gas formation, distention and diarrhea to a minimum, and (3) promotes the formation of soft, flocculent, easily digested curds. 'Dexin' *does* make a difference.

*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

'Dexin' HIGH DEXTRIN CARBOHYDRATE

BRAND

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.
'Dexin' Reg. Trademark

Literature on request

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 East 41st St., New York 17, N. Y.



Outstanding clinical endocrinologists, both here and abroad, have commented on the brighter mental outlook displayed by women receiving "Premarin." Not only does "Premarin" impart a feeling of "well-being" but it offers many other advantages as well.

It is orally active.
It is well tolerated.
It is promptly effective in controlling the menopausal syndrome.

"Premarin" is supplied in three potencies—tablets of 2.5 mg , 1.25 mg. and 0.625 mg. It is also available in liquid form containing 0.625 mg. in each 4 cc. (1 teaspoonful).

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are also present in varying small amounts, probably as water-soluble sulfates. The water solubility of conjugated estrogens (equine) permits rapid absorption from the gastrointestinal tract.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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CONJUGATED ESTROGENS
(equine)

"Premarin"®

AYERST, McKENNA & HARRISON Limited

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It is during that all-important first year of life that the very foundation of *future* health and ruggedness is laid. And the well nourished baby is, in most cases, more resistant to the common ills of infancy. Similac-fed infants are notably well nourished; for Similac provides fat, protein, carbohydrate and minerals, in forms that are physically and metabolically suited to the infant's requirements. Similac dependably nourishes the bottle-fed infant—*from birth until weaning.*

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SIMILAC

Similar to breast milk

A powdered, modified milk product, especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat has been removed and to which has been added lactose, cocoanut oil, cocoa butter, corn oil, and olive oil. Each quart of normal dilution Similac contains approximately 400 U.S.P. units of Vitamin D and 2500 U.S.P. units of Vitamin A as a result of the addition of fish liver oil concentrate.

Uniformity

Dependability in digitalization and maintenance

Sensible economy



Pil. Digitalis (*Davies, Rose*)

0.1 Gram (1½ grains)

Physiologically Standardized

Each pill contains 0.1 Gm. (1½ grs.) Powdered Digitalis, produced from carefully selected leaf of Digitalis purpurea, therefore of an activity equivalent to 1 U.S.P. XII Digitalis Unit.

When Pil. Digitalis (*Davies, Rose*) are dispensed on a prescription, the physician is assured that the patient receives digitalis in its completeness and obtains the full benefit of the therapy.

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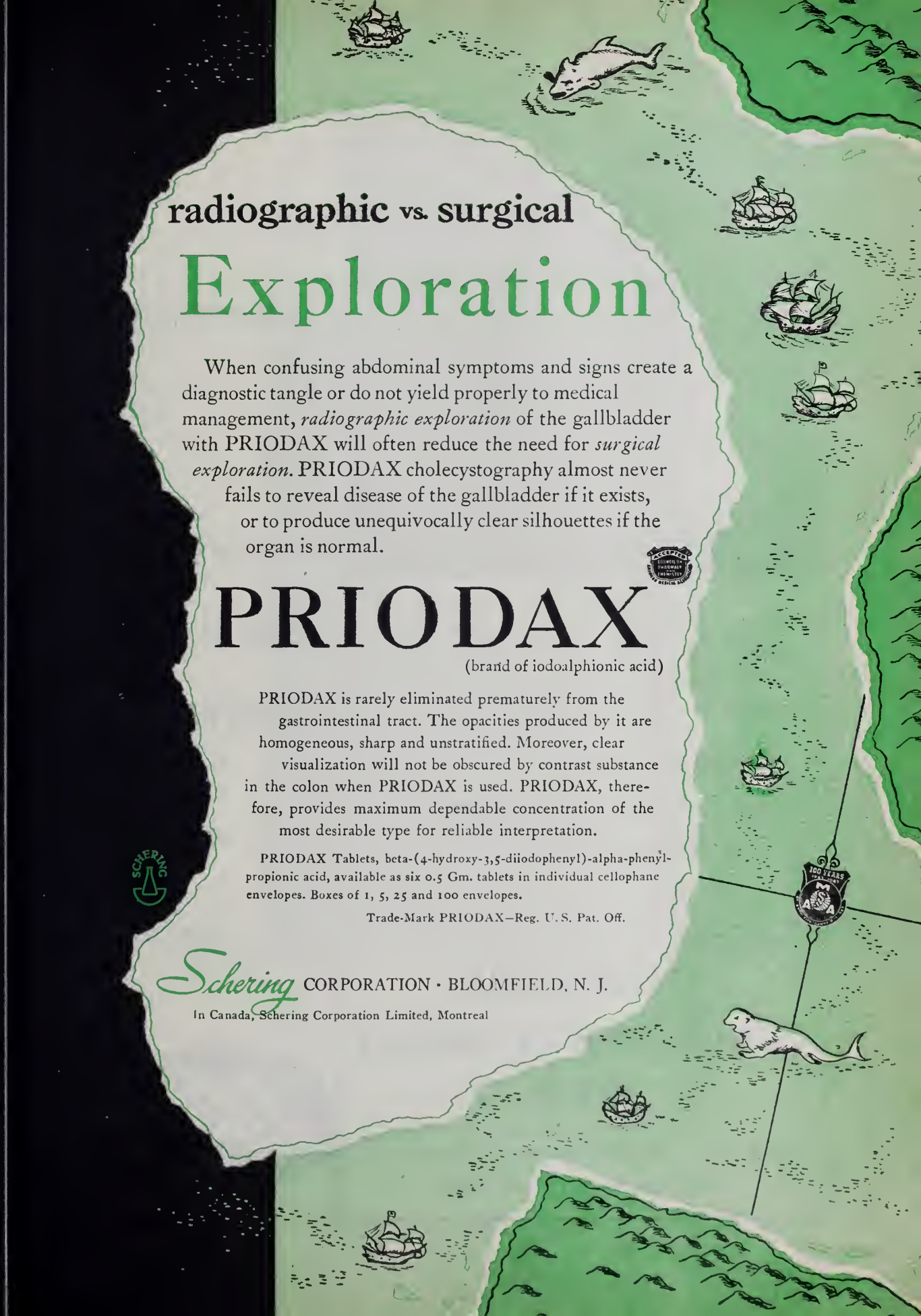
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Kindly send information on limits and costs of Society Professional Policy.

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radiographic vs. surgical

Exploration

When confusing abdominal symptoms and signs create a diagnostic tangle or do not yield properly to medical management, *radiographic exploration* of the gallbladder with PRIODAX will often reduce the need for *surgical exploration.* PRIODAX cholecystography almost never fails to reveal disease of the gallbladder if it exists, or to produce unequivocally clear silhouettes if the organ is normal.

PRIODAX

(brand of iodoalphionic acid)

PRIODAX is rarely eliminated prematurely from the gastrointestinal tract. The opacities produced by it are homogeneous, sharp and unstratified. Moreover, clear visualization will not be obscured by contrast substance in the colon when PRIODAX is used. PRIODAX, therefore, provides maximum dependable concentration of the most desirable type for reliable interpretation.

PRIODAX Tablets, beta-(4-hydroxy-3,5-diiodophenyl)-alpha-phenyl-propionic acid, available as six 0.5 Gm. tablets in individual cellophane envelopes. Boxes of 1, 5, 25 and 100 envelopes.

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In Canada, Schering Corporation Limited, Montreal



Announcing

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NEW

IMPROVED

FORM OF

STREPTOMYCIN

The development of Streptomycin Calcium Chloride Complex Merck constitutes an important advance in Streptomycin therapy. This improved form of Streptomycin provides these noteworthy advantages:

- INCREASED PURITY
- MINIMUM PAIN ON INJECTION
- UNIFORM POTENCY

STREPTOMYCIN
CALCIUM CHLORIDE COMPLEX
MERCK

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

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LITERATURE AVAILABLE ON REQUEST

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not later than 14 days

Investigators* now stress starting *early* with antirachitic measures. An unsurpassed source of natural vitamins A and D, White's Cod Liver Oil concentrate is wholly derived from cod liver oil itself. Palatable, potent, economical: average prophylactic drop dosage for infants costs but a penny a day. Liquid, Tablet and Capsule forms.

White Laboratories, Inc., Newark, New Jersey.

*Bibliography on request



rickets?
at this age?

Even in the 10 to 11 year age group, the incidence of rickets is reported to be high.* Protection throughout adolescence is essential—and youngsters gladly follow directions when the antirachitic tastes as good as White's Cod Liver Oil Concentrate Tablets. Each tablet provides as much vitamin A and D as one teaspoonful of cod liver oil.**

White's Cod Liver Oil Concentrate is wholly derived from time-proved cod liver oil itself. Potent, very palatable, most economical. Liquid, Tablet and Capsule forms.

White Laboratories, Inc., Newark, New Jersey.

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**U.S.P. Minimum Standards

SUBSTANTIATE YOUR DIAGNOSES WITH THIS G-E PORTABLE X-RAY





This powerful, 100 per cent shockproof x-ray, atop your office desk or in the home of your inambulant patients — provides you with a sure way of obtaining information you desire to substantiate your diagnoses.

It's easy to operate. With its simplified control you can easily and quickly make examinations of possible fractures, gross pathologies and foreign bodies with satisfying results.

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It's the lightest unit of its compactness and flexibility ever built—comes in a neat carrying-case . . . is easy to assemble and disassemble. And because of its low cost is well within reach of every practicing physician.

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Exacting head linesman



dietary dub!

He sees that first-downs are measured accurately, but he lets his diet be measured by the whims of his appetite. Sooner or later he faces the penalty of subclinical vitamin deficiency—along with a host of other self-made victims: *food-faddists*, excessive smokers, alcoholics, those on self-imposed and ill-advised reducing diets, patients "too busy" to eat properly, to name only a few. When such patients come to you, dietary reform is your first thought. Your second may well be a suitable vitamin supplement. For these cases, consider the advantages of specifying Abbott Vitamin Products: known quality . . . assured potency . . . wide variety to fit every vitamin need—in supplemental or therapeutic levels of dosage, in oral or parenteral forms, in single or multiple vitamin preparations. Abbott Vitamin Products are readily available at all prescription pharmacies.

ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS

. . . . . SPECIFY **Abbott Vitamin Products**

"don't smoke"...

IS ADVICE HARD FOR PATIENTS TO SWALLOW!

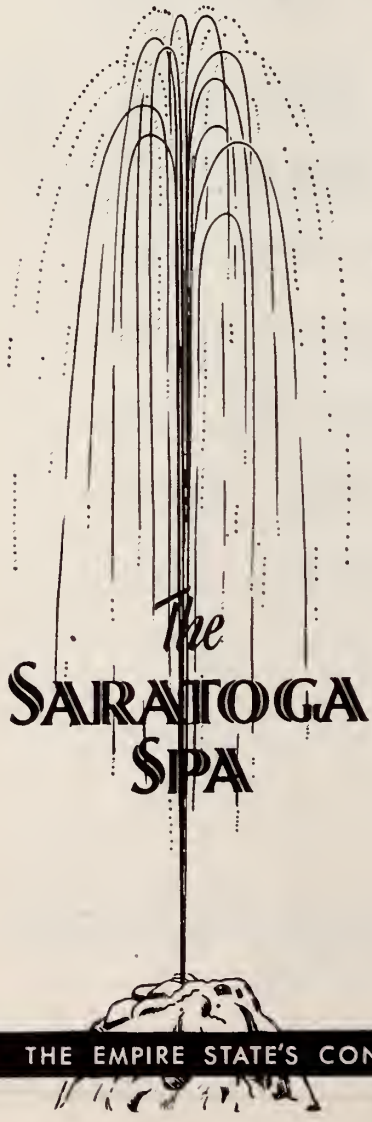
May we suggest, instead, *SMOKE "PHILIP MORRIS"?* Tests* showed 3 out of every 4 cases of smokers' cough cleared on changing to PHILIP MORRIS. Why not observe the results for yourself?

*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.



We Share with You the Care of Your Patient



Here at the Spa, the care of your patient conforms to a medical guidance which you, yourself, have initiated.

Capable physicians are available in Saratoga Springs for consultation with your patient on the details of the program.

Surrounded by modern facilities for his treatment, your patient receives the benefit of your continuing medical direction in the care of circulatory and rheumatic disorders of a chronic nature.

In peace and quiet, a sick person achieves the mental and physical relaxation that gives full scope to the restorative powers of the Spa's famed waters.

"PHYSICIAN, GIVE HEED TO THINE OWN HEALTH"

Many physicians have come to the Spa for the same kind of treatments that have helped their patients here. After a restorative "cure" at the Spa, you, too, will return to your practice refreshed—revitalized—ready for the busy days that lie ahead.

For professional publications of the Spa, and physician's sample carton of bottled waters, with their analyses, write W. S. McClellan, M. D., Medical Director, Saratoga Spa, 159 Saratoga Springs, New York.

Listed by the Committee on American Health Resorts of the American Medical Association

THE EMPIRE STATE'S CONTRIBUTION TO THE MEDICAL PROFESSION

recent definitive findings on

Benzedrine Sulfate

in the treatment of overweight

A conclusive study* on the action of amphetamine in weight reduction brings out four significant points:

1. With BENZEDRINE SULFATE "the obese subjects lost weight when placed on a diet which allowed them to eat all they wanted three times a day . . ." Later, these same overweight subjects continued to lose weight when allowed to eat—if they so desired—before retiring.

2. ". . . amphetamine definitely decreased the intake of food. . ."

3. ". . . amphetamine-induced loss of weight is almost entirely due to anorexia."

4. "No evidence of toxicity of the drug as employed in these studies was found."

*Harris, S.C.; Ivy, A.C., and Searle, L.M.: The Mechanism of Amphetamine-Induced Loss of Weight: *A Consideration of the Theory of Hunger and Appetite*, J.A.M.A. *134*:1468 (Aug. 23) 1947.

Benzedrine Sulfate

(*racemic amphetamine sulfate, S.K.F.*)

tablets capsules elixir

Accepted by the Council on Pharmacy and Chemistry of the AMA for use in treatment of overweight.

Smith, Kline & French Laboratories, Philadelphia

112 diagnostic *Allergens*



FOOD ALLERGENS

Almond
Apple
Apricot
Asparagus
Banana
Barley
Bean
Beef
Beet
Brazil Nut
Broccoli
Buckwheat
Cabbage
Cantaloupe
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Cauliflower
Celery
Cheese, American
Cheese, Swiss
Cherry
Chicken
Clam, Hard
Cocoa
Cocoanut
Codfish
Coffee
Corn
Crab
Cucumber
Duck
Eggwhite
Eggyolk
Flounder
Gelatin
Ginger
Grape (Raisin)
Grapefruit
Halibut
Herring
Honeydew
Lactalbumin
Lamb
Lettuce
Lima Bean
Lobster
Mackerel
Milk (Cow)
Mushroom
Mustard
Oat
Onion
Orange
Oyster
Pea
Peanut
Pecan
Pepper (Red, Green)
Perch
Pike
Pineapple
Pork
Potato
Prune (Plum)
Pumpkin
Quince Seed
Radish
Rice
Rye
Salmon
Sardine
Scallop
Shrimp
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Strawberry
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Veal
Walnut (English)
Wheat
Whitefish (Lake)
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INCIDENTAL ALLERGENS

Cotton Seed
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Gum Karaya
Kapok
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Pyrethrum
Silk
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Cat Hair
Cattle Hair
Dog Hair
Goat Hair
Feathers, mixed
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Rabbit Hair
Sheep Wool

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Alternaria sp.
Aspergillus fumigatus
Chaetomium sp.
Cladosporium
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Hormodendron
Monilia sitophila
Mucor plumbeus
Penicillium digitatum
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Arlington

THERE is increasing evidence that, in asthma, gastrointestinal allergies, infantile eczema, migraine, etc., treatment of allergic sensitivities is yielding gratifying results.

To facilitate diagnosis, Arlington offers a specially prepared assortment of 112 diagnostic allergens representing the most commonly reported causative factors . . . foods, epidermals, fungi and incidentals. Each vial contains sufficient material for at least 30 tests. Full instructions for the simple scratch-test technique and a supply of N/20 NaOH are included.

These dry allergens remain active indefinitely at room temperature. The allergens listed represent the standard Arlington selection. If preferred you may make your own selection of 112 allergens from our current list, available upon request.

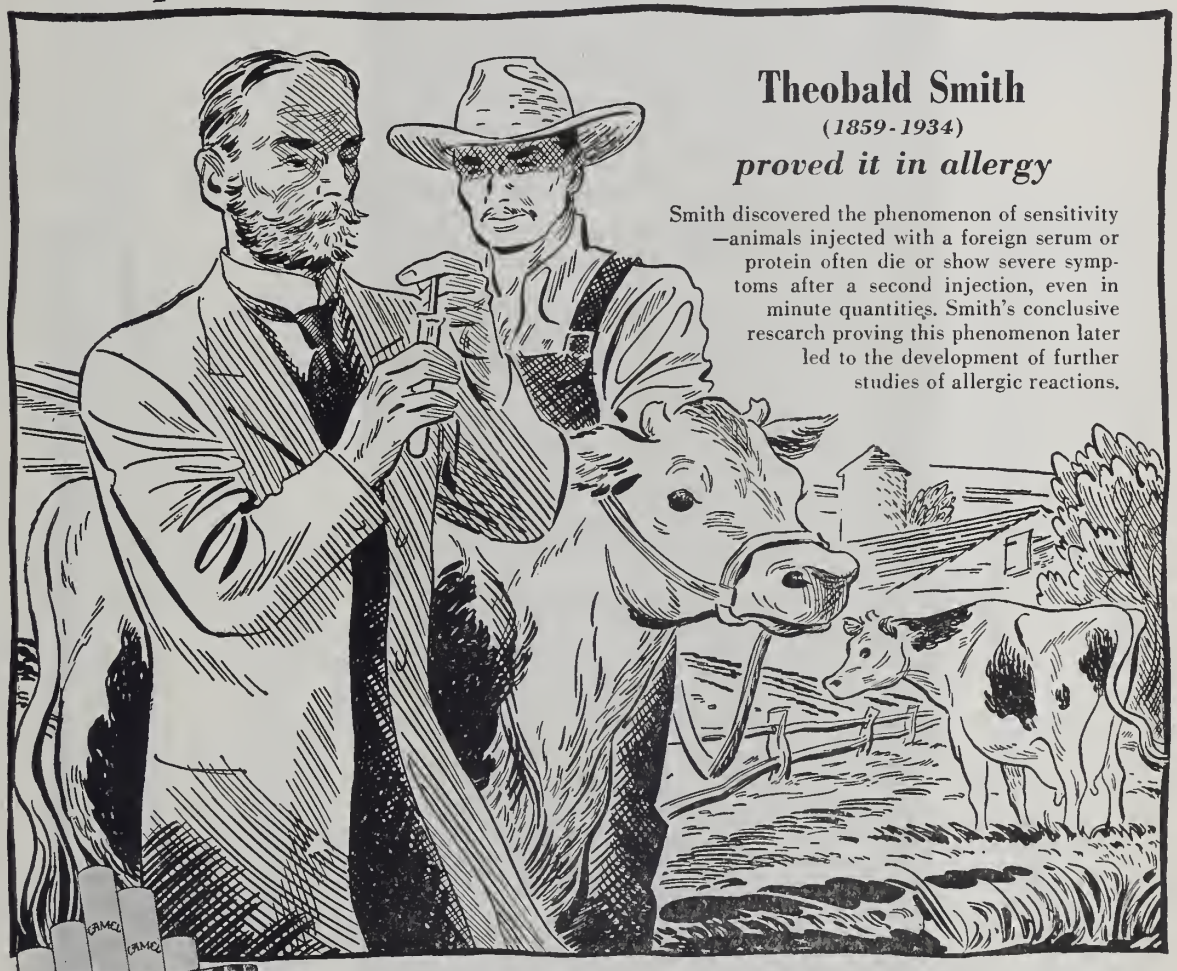
$35.00 ALLERGY DIAGNOSTIC SET

Biological Division

THE ARLINGTON CHEMICAL COMPANY

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Experience is the Best Teacher



Theobald Smith

(1859-1934)

proved it in allergy

Smith discovered the phenomenon of sensitivity —animals injected with a foreign serum or protein often die or show severe symptoms after a second injection, even in minute quantities. Smith's conclusive research proving this phenomenon later led to the development of further studies of allergic reactions.



Yes, and experience is the best teacher in smoking too!

EXPERIENCE during the wartime cigarette shortage taught smokers the differences in cigarette quality. In those days, people smoked —and compared—many different brands. That's the experience from which so many smokers learned that Camels suit them best. **As a result, more people are smoking Camels than ever before.**

Try Camels! Let *your* taste and throat tell you why, with millions who have tried and compared, Camels are the *choice of experience!*

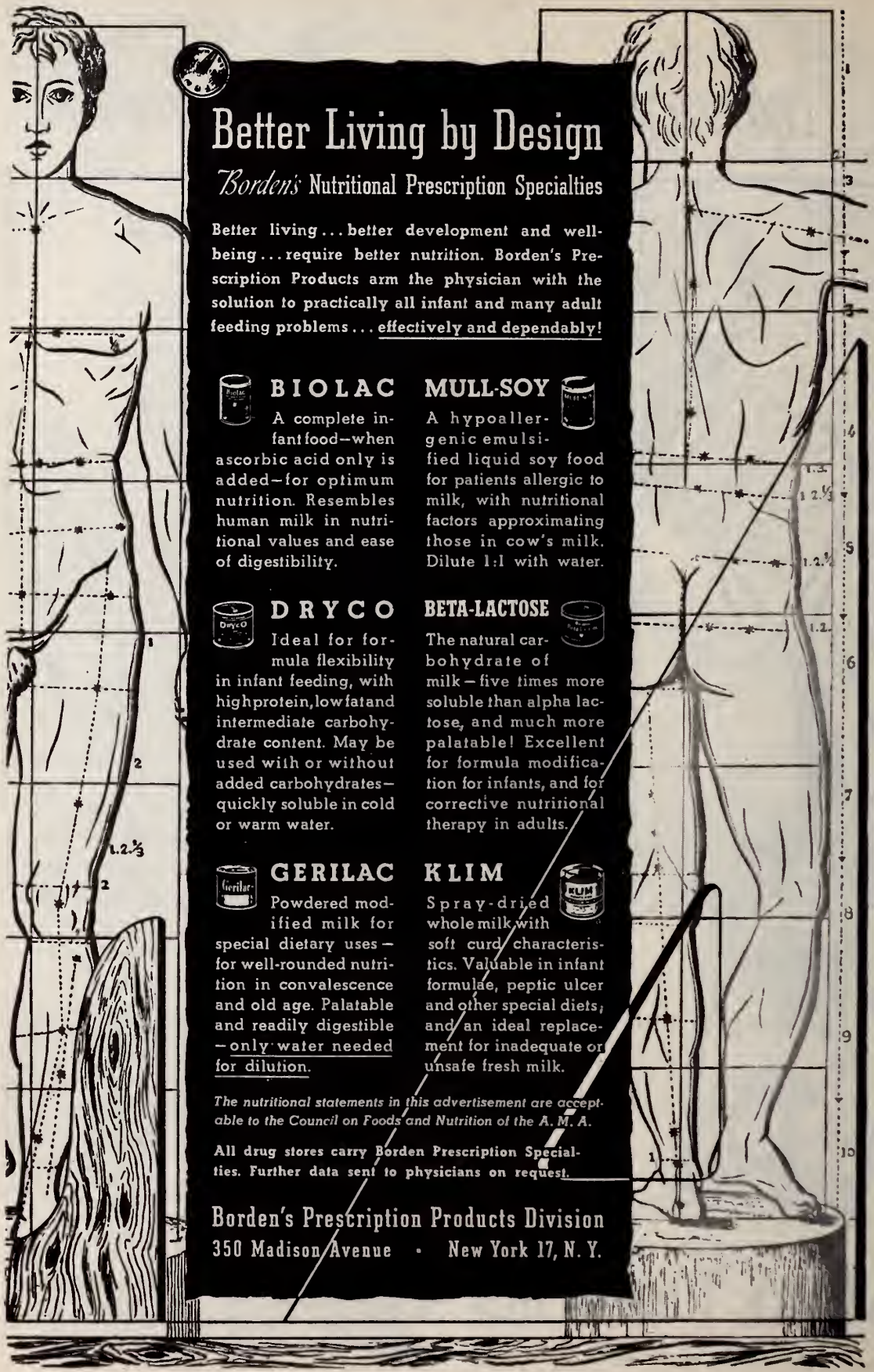


According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina



Better Living by Design

Borden's Nutritional Prescription Specialties

Better living . . . better development and well-being . . . require better nutrition. Borden's Prescription Products arm the physician with the solution to practically all infant and many adult feeding problems . . . effectively and dependably!

BIOLAC

A complete infant food—when ascorbic acid only is added—for optimum nutrition. Resembles human milk in nutritional values and ease of digestibility.

MULL-SOY

A hypoallergenic emulsified liquid soy food for patients allergic to milk, with nutritional factors approximating those in cow's milk. Dilute 1:1 with water.

DRYCO

Ideal for formula flexibility in infant feeding, with high protein, low fat and intermediate carbohydrate content. May be used with or without added carbohydrates—quickly soluble in cold or warm water.

BETA-LACTOSE

The natural carbohydrate of milk—five times more soluble than alpha lactose, and much more palatable! Excellent for formula modification for infants, and for corrective nutritional therapy in adults.

GERILAC

Powdered modified milk for special dietary uses—for well-rounded nutrition in convalescence and old age. Palatable and readily digestible—only water needed for dilution.

KLIM

Spray-dried whole milk with soft curd characteristics. Valuable in infant formulae, peptic ulcer and other special diets; and an ideal replacement for inadequate or unsafe fresh milk.

The nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the A. M. A.

All drug stores carry Borden Prescription Specialties. Further data sent to physicians on request.

Borden's Prescription Products Division
350 Madison Avenue • New York 17, N. Y.

Facts regarding *fluidity* of PENICILLIN in oil and wax

When penicillin in oil and wax is to be used once daily, the most important consideration is the maintenance of therapeutic blood levels for 24 hours.

For easy administration and adequately sustained blood levels, the formula must be neither too viscous nor too fluid . . . the penicillin crystals of correct size, shape and density . . . the container appropriate to the use intended. The following should also be recognized:

1 For administration from multiple-dose vials, the mixture should be sufficiently fluid to permit easy withdrawal, accurate measurement and easy injection.

2 In all fluid preparations, however, the penicillin has a tendency to settle out. Unless the container has adequate air space and volume to permit resuspension of the settled penicillin by shaking, 24 hour blood levels may not be maintained. Either overdosage or underdosage may result.

3 When injected from individual-dose cartridges, the penicillin in oil and wax suspension should be of slightly thicker consistency. If it is not, and the penicillin settles out, it cannot be resuspended by shaking, because (a) the volume is too small, and (b) the cartridge has no air space.

4 The slightly heavier type of suspension can be easily injected in accurate dosage with a minimum of discomfort to the patient. It is essentially free-flowing at room temperature, and each cartridge contains a full 1 cc. (300,000 unit) dose, which eliminates the need of measuring.

In keeping with Squibb policy of making the form of the product appropriate to the use, two forms of Squibb Penicillin G in Oil and Wax are available. Each offers the advantages of proper formula and consistency.

For easy, individual injections in home, office and emergency:

SQUIBB PENICILLIN G IN OIL AND WAX

Essentially free-flowing at room temperature: in Double-cell Cartridges for use with B-D* disposable or permanent syringe.

*T. M. REG. BECTON, DICKINSON & CO.

For easy, mass injections in clinic, hospital, or office, the new 10 cc. vial of

SQUIBB LIQUID PENICILLIN G IN OIL AND WAX

Resuspension readily attained; easy to inject; no withdrawal difficulties.

This is the new Monitor Control for the famed Picker "Century" 100 MA combination radiographic-fluoroscopic x-ray apparatus. It actually *performs* what automatic control systems often merely *promise.* Let your local Picker representative tell you how much easier; how much more *foolproof* it makes x-ray technical operation.

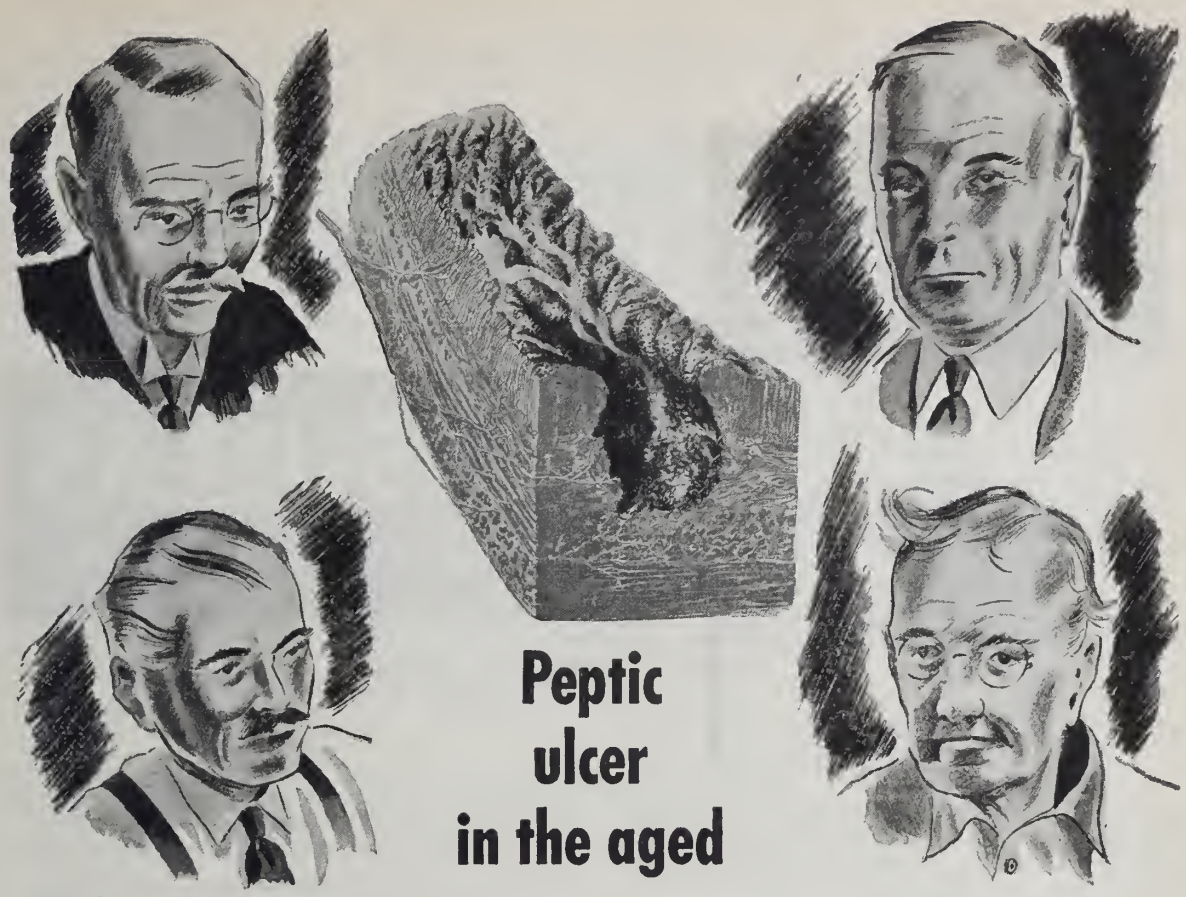
the new PICKER Century monitor control

PICKER

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PICKER IN NEW JERSEY IS AT 972 BROAD STREET, NEWARK 2, *(Mitchell 2-0482)*



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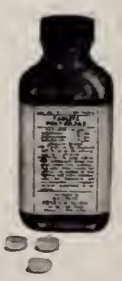
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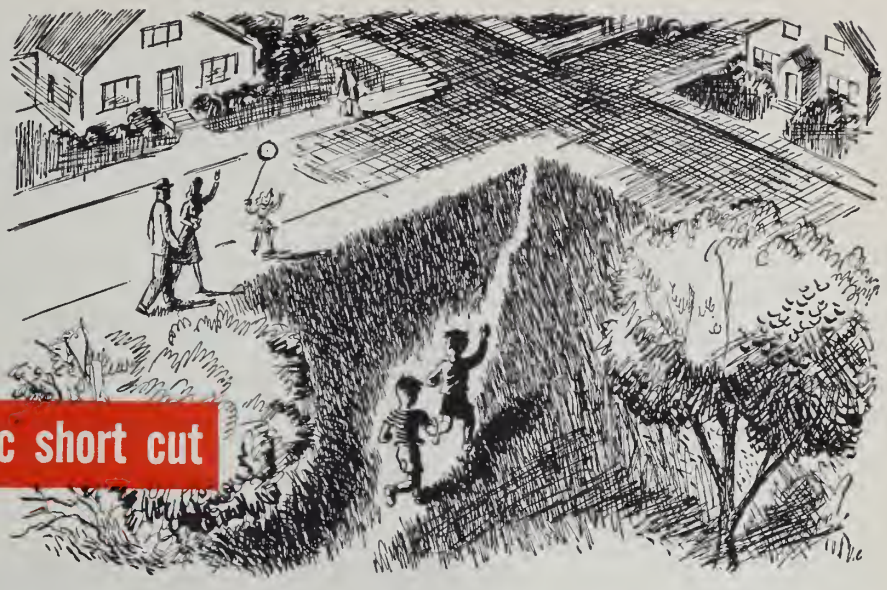
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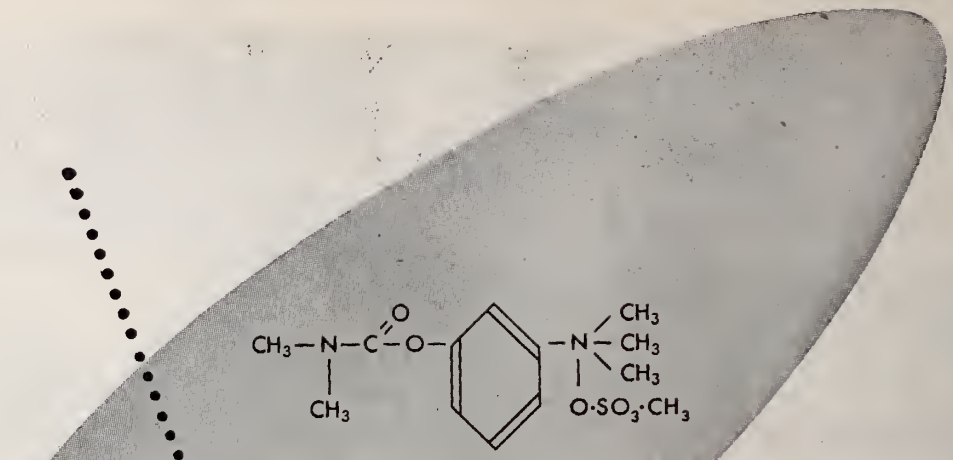
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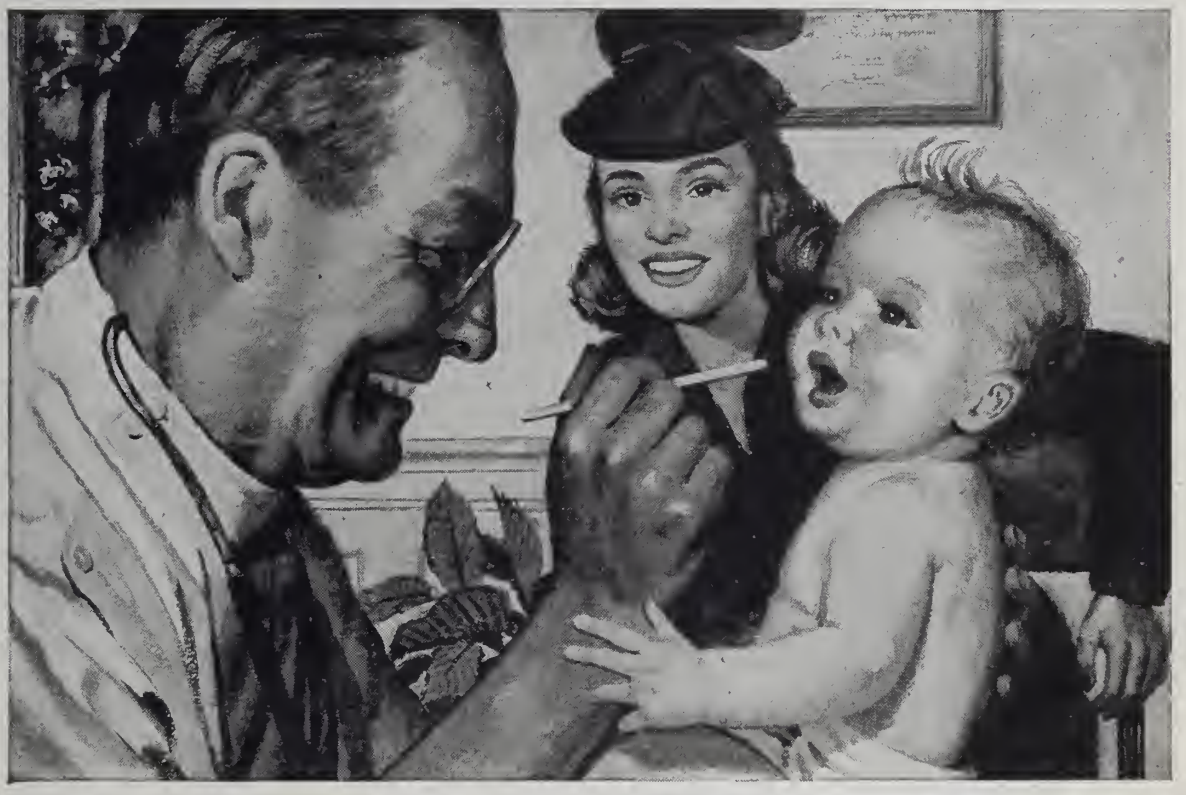
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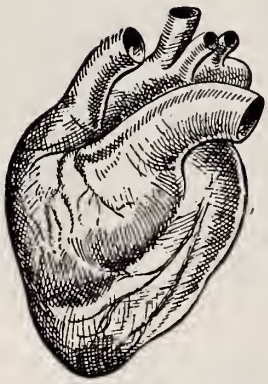


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Miriam N. Armstrong,
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THE PRESIDENT'S PAGE

CORPORATE PRACTICE OF MEDICINE BY HOSPITALS

One of the pressing problems confronting the medical profession today is the corporate practice of medicine by hospitals. By this term we mean the employment of specialists in the so-called "auxiliary services" — roentgenology, anesthesiology, physiotherapy, and clinical pathology — on a full-time salary basis. Corporate practice of medicine is prohibited by the Medical Practice Acts of many states. For years, it has been almost universally condoned when practiced by hospitals; nevertheless it is illegal. We have long recognized that hospitals have been practicing corporate medicine, but the custom has grown insidiously and has never been challenged effectively either by individual physicians or medical organizations. The profession as a whole has viewed this practice complacently and by now it is thoroughly entrenched and can be corrected only by coordinated action between state medical societies and state hospital associations. Many factors are involved; these include: (1) the complexion and attitude of lay boards of hospital trustees who, faced with rising costs of hospital management, are only too often willing and eager to augment hospital income by invading the field of medical practice; (2) the inclusive service provisions of the rapidly spreading Blue Cross Plan policies; and (3) the lack of awareness of the inevitable results of present trends and tendencies on the part of some practitioners of the auxiliary services.

What can be done to correct existing conditions? We in New Jersey are convinced that little or nothing can be accomplished by state societies acting alone or even by the American Medical Association in the effort to stem the rising tide of hospital encroachment upon the field of medical practice. We have battled with this problem for years but have

succeeded in doing little more than nibble at its fringes. It can be solved only by action on a national scale by the special societies concerned. Every professional body has the right to adopt a code of ethics and to enforce its observance by its membership without fear of legal penalties. The American Medical Association banned contract practice of any kind, until recent years, when the ban was modified somewhat to meet the changing requirements of industrial and other forms of practice; but the code of ethics of the American Medical Association still clearly defines ethical and unethical forms of contract practice. The national specialty societies (such as the American Roentgen Ray Society) can solve the problem by evolving standard types of agreements with hospitals which would meet existing hospital requirements and which would still preserve the status of the specialists in the auxiliary fields as independent private practitioners of medicine. Such approved agreements can be declared ethical; all others can be declared unethical. Every member of the specialty societies can then be required to conform to these agreements under penalty of forfeiture of membership in his organization.

Much can, perhaps, be accomplished by negotiation with the Hospital Plan of New Jersey, The Medical-Surgical Plan of New Jersey, the New Jersey Hospital Association and boards of trustees of our voluntary hospitals to induce these groups to see the justice of our urgent request that the sale of physicians' services by hospitals be discontinued. The problem is complex and vexatious; but with patience, persistence and tact on our part, a satisfactory solution can be evolved.

Royal A. Schaaf, M.D.,
President,
The Medical Society of New Jersey.

THE NATIONAL GUARD NEEDS MEDICAL OFFICERS

Looking at the poster of Uncle Sam pointing his finger and saying that he needs you is enough to make many physicians snicker. They think back at their active military duty and say "Get somebody else, Uncle, —not me!" While this indifference to military service may be fashionable, it is hardly realistic. To dwell on the gripes of the past is a sterile and childish amusement. Certainly there were inequities in promotion, pay, rank and assignment. Those inequities were not limited to the Medical Corps. The surest way of preventing them is to infuse the military service with a rich leaven of practitioners, who will take an articulate part in military affairs and lend their efforts at improving the service.

Of the various Army components, the one most appealing to the civilian physician is the National Guard. It is, in large measure, a local enterprise, where the doctor's community standing can be given real meaning. For a few hours of time each week, it offers the physician a chance to acquire a wide acquaintance. A doctor in the Guard is the first physician thought of by personnel of the unit when sickness overtakes them or their families. The weekly evening at the armory is a pleasant relaxation and a refreshing change from the grind of practice. And the Guard medical officer is actually paid for taking this evening off. (Armory drill pay is from $6.66 to $12.22 a night). The weekly drill sessions bring the doctor into contact with other officers in a pleasant club-like atmosphere which fosters an esprit-de-corps and adds a new dimension to the art of living.

The physician who is sensitive to these values will obtain further information by writing to the Adjutant General, New Jersey National Guard, State House, Trenton, N. J.

ORIGINAL ARTICLES

COMBINED ANTIGENS IN THE TREATMENT OF RHEUMATOID ARTHRITIS

P. J. Warter, M.D., Trenton, N. J.; D. A. Donio, M.D., Allentown, Penna., and Steven Horoschak, B.S., Ridley Park, Penna.

The disease process of rheumatoid arthritis in most patients may run an active course of some months or even years, then become quiescent. It usually begins as a proliferative synovitis, but soon affects articular and periarticular tissues. The onset of rheumatoid arthritis in adults is frequently insidious, but many patients may show signs of infection.

ETIOLOGY

Though the significance of focal infection has been doubted by many observers, the practical application of this concept has proved its worth. As the *Journal of the American Medical Association*[1] aptly puts it:

"The concept of focal infection has been integrated into the practice of medicine. One speaks no longer of the *theory* of focal infection. One recognizes focal infection as a definite pathologic condition requiring scientific diagnosis and treatment."

According to Wiltsie,[2] focal infection in the colon is a common and important factor in rheumatoid arthritis. This is supported by Lautman[3] who writes:

"In recent years more and more importance is being attached to the colon as a possible factor in the production of arthritis and the part which the intestinal tract plays as a focus of infection is becoming more frequently stressed."

Of all the organisms believed to be responsible for focal infection, the streptococci are undoubtedly the most important. The evidence seems to support the streptococcal role in the etiology of rheumatoid arthritis. Warter et al,[4] commented that if the streptococcus itself is not the cause, then its toxins and toxic products may be considered contributing factors to rheumatoid arthritis.

Rosenow,[5] by ingenious experiments, has shown that strains of streptococci which are microscopically and culturally indistinguishable may have an affinity for different specific tissues in the host. He has exploited the phenomenon of elective localization[6] by injection into animals in establishing the relationship between certain foci of infection and a clinical manifestation.

Resistance against the streptococcus apparently involves a more generalized defense mechanism since small numbers of organisms must constantly penetrate beyond the local inflammatory barrier. Whether the secondary lesions are due to the actual transference of the organisms themselves, or due only to their toxins cannot be answered definitely. It may be that soluble proteins of the organisms absorbed from the primary focus are responsible in part, at least for tissue sensitization.

We may assume, according to Meyer,[7] that each entire toxin is composed of a mosaic of toxin moieties, each one perhaps primarily operative in a given area such as the skin or other tissues.

The doctrine of focal infection and the accepted role of bacteria with the existence of a relationship of elective affinity for certain tissues has been presented by Rosenow,[8] and Nakamura,[9] and substantiated by Haden.[10]

Consideration may be given to the idea that joint and muscle injured by previous exposures to streptococcal toxins become sensitized before they become susceptible to the toxins arising in a septic focus. The irritant sets up an acute inflammatory reaction, localizing it by the development of a lymphatic blockade which tends to wall off the irritant.

DIAGNOSIS

Physicians today have adequate laboratory facilities to assist in making a proper diagnosis. Any doctor making a diagnosis on an assump-

tion, (and then instituting therapy) is not doing justice to the patient nor to the profession.

The first requirement is a complete history. The patient will gain confidence in the physician and respect for his ability as he leads him through the "question and answer" period. At this time too, a dietary history is obtained.

X-rays of affected joints are ordered and appropriate laboratory tests, such as red and white cell counts, differential counts, sedimentation rate, liver function tests, urine analysis and calcium, phosphorus ratio determinations are requested.

The patient is given a thorough physical examination; the affected joints are studied as to swelling, function, deformity and pain.

Not until all this data has been compiled and analyzed is the patient put on any therapy, excepting analgesia for pain.

TREATMENT PROCEDURE

The treatment of rheumatoid arthritis requires proper management of all phases of the disease. Many physicians treat only the affected joints thus neglecting other important phases of necessary therapy.

Patients are required to take rest periods during the day, one hour in the morning and two hours in the afternoon. Exercises, suitable to the individual case, are outlined and proper massage prescribed.

The dietary history may reveal a deficiency in certain nutritional factors. We have found a combination of protein hydrolysate and vitamin B complex factors (aminovite) effective as a dietary supplement in these patients.

One of the important measures is to give the patient sufficient time at each visit to impress him with the fact that the physician is vitally interested in his condition and problems. Our first concern was to improve the mental attitude of each patient, which, in our opinion, is a "must" in the therapeutic regimen of an arthritic patient.

STREPTOCOCCUS-STAPHYLOCOCCUS ANTIGEN TREATMENT

The fundamental principle underlying this mode of therapy is to stimulate the unused immunizing capacities of uninfected tissues in the interest of infected tissues. If the treatment or the removal of the focus of infection cannot be accomplished, specific immunization and desensitization constitute an important method of altering the reaction of tissues to infection.

Unless the patient with rheumatoid arthritis assures the physician of cooperation in taking injections of the antigen at regular intervals over a long period of time, it will be of no therapeutic value. Immunity to streptococcus is developed slowly and seldom reaches a very high level. Antibody production is at times stimulated with small doses of an antigen, whereas large doses frequently tend to inhibit this process.

Warter et al,[4] stressed the importance of the proper preparation of the bacterial vaccine with toxin, and toxoid to be used as a combined antigen in the treatment of rheumatoid arthritis. Many investigators[11,12,13,14] reported better immunologic response to a combination of vaccine and toxoid than they had observed from the use of either one alone.

The formula of the combined antigen used in this study is as follows:

Staphylococcus aureus	1000 M/cc.
Staphylococcus toxoid	500 M.N.D./cc.
Streptococcus (hemolytic-non-hemolytic and viridans)	2000 M/cc.
Streptococcus toxin[15] (tannic acid precipitated)	1000 S.T.D./cc.

The combined antigen was given intramuscularly in the deltoid or gluteal region at weekly intervals. Initial dose in each case was 0.1 cubic centimeters, and if no severe reaction, (local or general) was manifested, the dose was increased by increments of 0.1 cubic centimeters until a full cubic centimeter was reached, which was established as the maximum dose. It was not possible to arrive at this maximum dose in all patients because of local, general or symptomatic reactions. If a certain dose of the combined antigen produced any one or a combination of reactions in any patient, this was designated as the maximum dose for that patient.

Each patient was continued on weekly injections of the maximum dose of strepto-staphylo-vaccine-toxin-toxoid combined anti-

gen, adapted to the tolerance of the patient for at least sixteen weeks. Then the injections were given at two week intervals. When satisfactory objective improvements were observed, injections were spaced one month apart. Occasional rest periods of several months were allowed patients showing appreciable clinical improvement.

CRITERIA OF IMPROVEMENT

The New York Rheumatism Association's recommendations for assaying improvement in rheumatoid arthritis patients were used. To provide a convenient and reliable means of assaying improvement, the Committee recommends four categories of response, denominated Grades I, II, III and IV. Grade I represents the maximum response to treatment; Grade IV, no response. The criteria are based entirely on objective evidence since subjective symptoms are considered unreliable.

GRADE I—COMPLETE REMISSION: CRITERIA:

1. Absence of systemic signs of rheumatoid activity such as leucocytosis and fever.
2. Signs of joint inflammation and of intra-articular and peri-articular swelling to have resolved.
3. No new development of rheumatoid activity, including new joints, nodules or tendonitis.
4. Remaining impairment of joint function not to be due to inflammation, muscular spasm or pain.
5. The erythrocyte sedimentation rate within normal limits regardless of method used.

If this degree of improvement is maintained for a period of five years, the disease is considered to be arrested.

GRADE II—MAJOR IMPROVEMENT: CRITERIA:

1. Absence of systemic signs of rheumatoid activity such as leucocytosis and fever.
2. Signs of joint inflammation, such as heat and redness, to have subsided completely and joint swelling to be absent or minimal.
3. No new rheumatoid process of intra-articular or extra-articular nature.
4. Remaining impairment of joint function due to muscular spasms to be absent or minimal.
5. Moderately elevated erythrocyte sedimentation rate, equivalent to a maximum of 50 millimeters per hour by the Westergren method, permissible.

GRADE III—MINOR IMPROVEMENT: CRITERIA:

1. Diminution of rheumatoid signs to any degree.
2. Increased functional capacity, general or local without fulfilling the criteria of Grade II improvement.

In view of the natural course of the disease and the inherent difficulties in evaluating therapeutic agents over an arbitrary period of observation, the Committee feels that the results in patients who manifest this degree of improvement should not be considered significant and, therefore, should not be included in any favorable summary of a therapeutic agent or procedure.

GRADE IV—CRITERIA:

1. Unaltered rheumatoid activity or general functional capacity.
2. Exacerbation of any previously involved joint or joints, or development of new joint activity.
3. In the presence of the above, normal or lowered erythrocyte sedimentation rate not significant.

Subjective evidence by itself is regarded as insignificant and without objective signs of response, the patients classified as unimproved.

RESULTS

The patients in this clinical study had been on other types of therapy without appreciable improvement, some were getting progressively worse. Gold preparations had been used and found to be non-effective. In a number of cases, gold produced such reactions as to warrant discontinuing this type of therapy. These patients were placed on streptococcus-staphylococcus-vaccine-toxin-toxoid combined antigen and treated as outlined above.

Some of the patients had relief from pain following the third or fourth injection of the combined antigen. This phenomenon may be considered a desensitization of a possible bacterial allergy. These patients improved rapidly with relatively small doses of the antigen; seldom carrying the dose above 0.5 cubic centimeter in any of this group.

There were patients in whom the first several doses produced no reaction of any type. A decision was made to "push" these patients somewhat more vigorously; succeeding doses were increased by larger increments, until the full cubic centimeter dose was reached. The response in these patients was relatively slow, but eventually satisfactory, both objectively and subjectively. It was observed in this group that satisfactory therapeutic response was not dependent on the production or manifestation of reactions in the patients.

Symptomatic reactions were experienced by

a few of the patients in whom the dose of the combined antigens was increased too rapidly. These patients complained of exacerbation of their symptoms and increased pain. Would it be correct to postulate that these patients manifested some degree of bacterial or bacterial toxin sensitization? Two patients were so affected that they refused further injections of the antigens. All others were placed on considerably reduced doses, in most cases going back to the first dose, 0.1 cubic centimeters, and gradually increasing each succeeding dose until one-half of the reaction producing dose was reached. Patients in this group were maintained on this dose, in each case, as the maintenance dose.

Reactions of a local nature (either early or late) were observed in some of the patients. Complaints relating to these reactions were unusual, and our explanations were readily accepted.

Occasionally, some complained of malaise, nausea, chills and fever, and other signs indicative of possible general toxic reactions. In these patients, the antigen was discontinued for a short time, then resumed with one-half of the reaction producing dose, and given every two weeks instead of at weekly intervals. Whether these reactions may be considered as a systemic response to the specific or nonspecific toxins contained in the combined antigen is of less importance than the degree of improvement, objective and subjective, manifested in these patients following such reactions.

Ninety patients were treated and observed for periods of two, three and four years. The number of patients, male and female, their average ages and the average duration of their arthritis is given in Table I. Clinical results are displayed in Table II.

COMMENT

The focal sepsis idea, though belittled by many investigators, seems to be regaining supporters. It at least offers a definite starting point, with sufficient evidence to make it practical and to indicate that the idea is basically correct. Arthritis can certainly follow an acute focal sepsis, such as pharyngitis or septic sore throat.

Davidson and Goldie[16] gave logical reasons for supporting the focal sepsis idea:

> "When a patient presents an arthritis and in whom there is undoubtedly a source of infection which cannot be found, it is not unreasonable to presume by analogy that infection is present and the difficulty in discovering the infective agent would be explained whereby the focus exists in a site inaccessible to easy investigation or remaining unrecognized because of its low grade character. In the latter case the effects of the infection can be explained on the basis of abnormal tissues susceptible to sensitization, constitutionally or actively acquired."

It behooves the physician to make an exhaustive search for possible foci of infection and acknowledge them as "definite pathologic conditions requiring scientific diagnosis and treatment". Conservative treatment and sound medical judgment are suggested in this phase of rheumatoid arthritis therapy.

The streptococci have been indicted most frequently as the etiologic factor in rheumatoid arthritis. We offered the opinion that, if not the streptococcus itself, then its toxins and toxic products are contributing factors to the pathology manifested in rheumatoid ar-

TABLE I.

Years Observed	Number Patients			Average Age			Average Duration Arthritis		
	F	M	Total	F	M	Both	F	M	Both
4	14	3	17	47.5	55.7	49	3	10	3.6
3	17	12	29	53.2	43.5	49.5	11.7	8.45	10.6
2	32	12	44	47.9	50.8	48.9	7.54	14.5	8.6

TABLE II
RESPONSE TO THERAPY

Years Observed	Group I*		Group II*		Group III*		Group IV*	
	F	M	F	M	F	M	F	M
4	3	2	6	1	2	0	3	0
3	6	4	8	5	3	2	0	1
2	10	4	12	3	6	3	4	2
Totals	29		35		16		10	

* Group I. Considered to be arrested.
* Group II. Considered to be controlled.
* Group III. Minor Improvement.
* Group IV. Unimproved or Worse.

thritis. In the early stages of arthritis, there exists a disturbance in the physiologic processes which, in all probability is of a functional nature, permitting the deleterious actions of the infective processes to manifest themselves in organic changes. The more chronic the disease becomes, the greater the possibility of tissue sensitization resulting from the soluble bacterial proteins and toxins absorbed from the primary focus.

On the premise that foci of infection, streptococci, and their toxins or toxic products play some role in the etiology of rheumatoid arthritis, we decided to incorporate into our therapeutic regimen, the use of streptococcus-staphylococcus-vaccine-toxin toxoid combined antigen. Sole reliance was not placed on this antigen as a therapeutic agent; it was incorporated in the regimen as a supplement. If the doctor treats the patient rather than the joints better results can be anticipated.

Gold therapy is being used less frequently and more cautiously. This is because of the possible toxic and dermatologic reactions. Clinical results with the streptococcus-staphylococcus-vaccine-toxin-toxoid combined antigen have been as favorable, and in a number of patients, more favorable than obtained with gold therapy. If the action of gold therapy is to alter the biologic activity of tissue sensitized to infection, then the combined antigen is much safer to use for the same purpose.

SUMMARY

Treatment of rheumatoid arthritis should be directed against the etiologic factors, rather than simply against the affected joints. The need for proper mental and physical rest; maintenance of adequate nutrition, control of pain, and eradication of obvious foci of infection, are essential to the successful treatment of rheumatoid arthritis. Proper exercise and massage should be included at the proper time.

Supplementing the therapeutic regimen of rheumatoid arthritis with streptococcus-staphylococcus-vaccine-toxin-toxoid combined antigen, as described, proved effective in arresting and controlling rheumatoid arthritis in 71.1 per cent of the 90 patients observed from two to four years, as assayed by the method of the New York Rheumatism Association. Of these, 32.2 per cent are classified in Group I and 38.9 per cent in Group II. There were 17.8 per cent in Group III, and only 11.1 per cent in Group IV.

These observations and results confirm those previously reported.

CONCLUSIONS

A streptococcus-staphylococcus-vaccine-toxin-toxoid combined antigen, as described and prepared according to suggestions in our initial report, should be included in each physician's therapeutic regimen for rheumatoid arthritis.

We express our appreciation to the Medical Research Laboratories of The National Drug Company, Philadelphia, for supplying the streptococcus toxin bacterial suspension and staphylococcus toxoid bacterial suspension combined antigen for this study.

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CALLING ALL ALLERGISTS

All physicians interested in helping form a New Jersey Allergy Society are invited to communicate with any one of the following: Dr. William Greifinger at 31 Lincoln Park, Newark; Dr. Frank Rosen at 33 Johnson Avenue, Newark, or Dr. Nathan Schaffer at 172 South Arlington Avenue, East Orange.

PRURITUS ANI: A BIOCHEMOPHYSIOLOGIC ENTITY

Harry E. Bacon, M.D.,* and
Clifford E. Hardwick, M.D.*
Philadelphia, Pa.

Our interest in the study of pruritus ani was augmented by the recent work of Slocumb [1] and the earlier pathologic investigations of Montague,[2] Montgomery,[3] Hellwig and Tucker.[4]

The hypothesis that anal pruritus is not due to local pathologic changes exclusively, but that additional causative influences exist, was suggested by Allingham more than fifty years ago. He published his theory regarding this in 1882. Little credence, however, was attached to it and no reference made to his idea until Montague [2] published his book in 1924.

It would seem timely to review what is known of the biochemical physiology and histopathology of pruritus ani and to discuss our efforts to apply this knowledge in treating this stubborn syndrome. A series of 125 cases, the type and results of therapy utilized, will be reported herein.

PHYSIOLOGIC FACTORS

The normal physiologic mechanism of the anorectal region includes the perianal skin with its sweat gland-bearing area, the local blood and nerve supply, and the complicated physiology of the end products of digestion, secretions from which bathe this area. The anus and perineum are ideally suited for the inception of the symptoms of itching incident to pruritus.

The lower third of the anal canal is lined by true skin which is continuous over the perianal area. Sweat glands, sebaceous glands and hair follicles are present.

Functional activity of these glands influence the cultural environment of the area. There are two varieties of sweat glands, the eccrine or ordinary type, and the apocrine. The latter are found only where hair exists being situated deeply in the dermis. They begin to function at sexual maturity producing an excretion which has a higher pH than ordinary perspiration (eccrine type). Their composition of protein, carbohydrate and fat are similar to that of the eccrine glands except that the amounts of each component are larger and they lead in the production of cholesterol. This type of secretion existing between folds of the skin furnishes ideal culture media for many organisms. The excess carbohydrate normally present in the apocrine glands excretion may be increased by a diet high in starches and sweets.[5]

The nerves that supply this sensitive area are derived from branches of the dorsal nerve roots of the first, second, third and fourth sacral, and the first coccygeal segments. Physiologically, this region displays a maximum readiness to itch. Longo [6] states that the only other region having a similar excitability or a hypernormal nerve stimuli is the meatus of the external auditory canal.

The investigations of Tashian [7] on local immunity or the defense mechanism, has demonstrated that the cells of the reticulo-endithelial system, designated as Küpffer cells, or histiocytes comprise, to a great extent, the defense and repair mechanism of the skin. The normal physiologic acidity of the intestinal mucosa depends on this system and upon maintenance of the acid-base balance. By the same token, the response of the system depends, in part, upon this absorptive and oxidative reducing action of the mucous membrane.

The reaction [8] of the intestinal contents of the lower bowel varies from a pH of 4.4 to 7.4. The sensitiveness of the intestinal mucosa to the acid reaction of the gastric juice [9] increases from the duodenum on down. Mann and Bollman [9] have demonstrated that dietary measures may greatly alter the reaction of the contents of the gastrointestinal tract.

To evaluate the normal, or average pH of the rectal mucosa, a series of 35 cases presenting no evidence of pruritus ani were studied. The readings varied from a pH of 7 to 8, the average being 7.5.

BIOCHEMICAL FACTORS

The biochemical factors relevant to this entity are closely interwoven with the physio-

* Read by invitation before the Annual Meeting of The Medical Society of New Jersey, April 23, 1947. Dr. H. E. Bacon is Professor and Head of Department of Proctology at Temple University; Dr. C. E. Hardwick is Associate in Proctology, Temple University.

logic. Tucker and Hellwig,[4] concluded the changes present in pruritus ani were characteristic of a chemical dermatitis.

The theory of chemical irritation has also been postulated by Davis.[10] He believes that irritating, nonabsorbable chemical compounds are formed when certain substances from the bowel are brought into contact with the perianal skin and deposited there. Stoeber and Wacher[11] demonstrated that cutaneous changes can be produced by the injection of skatole which closely simulate those present in true pruritus ani. The products of protein putrefaction and of lactic acid carbohydrate metabolism and also the role played by indole and skatole have been demonstrated by the experiments carried out by Kendall.[12] Cannon[13] concluded that the intestinal flora vary directly with the hydrogen ion (pH) concentration, a pH of 7 being characteristic of a gas-producing proteolytic type whereas, an increasing acidity is characterized by a diminution of proteolytic types and their replacement by aciduric types mainly dominated by B. acidophilus. Sokoloff[14] demonstrated a method of changing the colonic flora by the use of a polymolecular lactic acid combined with lactose and demonstrated that due to the low absorptive activity of the mucous membrane, the bacterial flora becomes a decisive factor and the functioning power of the colon with its protective acidity depends, to a large extent on the presence of acidophilic flora. Slocumb, (op. cit.) concluded from his recent work on pruritus that the causative factor was a chemical irritant, alkaline in reaction, metabolic in origin and favorable to a correlation of the mucosal pH and the bacterial flora.

We are in accord with the concept that any imbalance of a chemical, bacterial or metabolic nature may alter or distort the intricate physiologic mechanism of the colon and anorectum.

Slocumb[1] demonstrated that the relative reduction of carbohydrates and the increase in proteins in the adult diet result in changes that are equivalent in bacterial flora. The normal carbohydrophilic bacteria are replaced by such types as Bacillus coli which thrives equally well in the presence or absence of carbohydrate. Lactic acid is formed from carbohydrate but in its absence, putrefactive products such as indole and skatol are produced from proteins. Skatol is absent from the stools of healthy children and most adults. Herter[15] demonstrated excessive amounts in the feces of patients suffering from mental depression, the anemias, and chronic intestinal disorders. These conditions are often associated with pruritus according to Montague.

HISTOPATHOLOGY

Detailed histopathologic studies of pruritus ani have been made by several investigators.

Montague[2] described an acute, or subacute exudative dermatitis whereas Montgomery,[3] expressed the belief that the skin changes corresponded closely to those encountered in neurodermatitis.

Tucker and Hellwig[4] reviewed the cutaneous changes in 43 cases of pruritus the essential features of which were: The epidermis is markedly thickened, the rete pegs elongated, papillary bodies narrowed,—all essentially an acanthosis. They demonstrated the presence of a thickened corium with perivascular infiltration and a dilatation of both blood and lymph vessels. In the cases encountered early, they discovered the protoplasm of some of the prickle cells to be entirely destroyed and occupied by a clear space with the nucleus pushed to one side; around these destroyed cells those of the prickle variety were unrecognizable. These authors divided pruritus into four histologic groups:

(1) The early cases with prickle-cell destruction.

(2) Later cases with marked hyperplasia or thickening of all layers of both epidermis and corium.

(3) Very late cases characterized by atrophy of the epidermis, and,

(4) Still later cases with epidermal defects and signs of secondary infection.

They concluded from their investigations that the underlying cause of pruritus ani very strongly suggested a form of chemical dermatitis. The investigations made by Whitney[16] confirmed those of Tucker and Hellwig[4] in nearly every instance.

From the preceding discussion, we have postulated that pruritus ani may be due to a disturbance in the acid-base balance which resulted in a change occurring in the bacterial flora, this, in turn raising the pH of the rectal mucosa. This alkaline reaction has been constantly present in the majority of our cases of pruritus. It is our opinion, based on previous histopathologic determinations, that pruritus ani, *per se,* is a form of chemical dermatitis varying in its skin changes. That the anal skin displays a maximum readiness to itch and

that the disturbed physiology of the sweat glands in this region may foster infection has been pointed out; additionally, the influence of diet, gastrointestinal or systemic disease on the bacterial flora has been described in detail.

Numerous cases of pruritus are also complicated by anorectal pathology, intestinal parasites of fungus infections. Routine correction of such pathology is definitely important in decreasing the precipitating factors.

TREATMENT

The form of treatment employed on our service follows:

(1) The taking of a careful history, especial attention being paid to the deletion of extraneous etiologic factors.

(2) A detailed proctologic examination.

(3) Laboratory examinations such as urinalysis, cultures for fungi and other pathologic organisms; examination of the stool for parasites; scrapings taken from the anal skin for making cultures and an estimation of the pH of the rectal mucosa.

Treatment is based on an evaluation of this information in each case as we individualize each patient on our service.

Grossly the appearance of skin changes in our cases of pruritus are divided into three classifications:

Group 1. The perianal skin varies from a reddish tint to the so-called "scalded" appearance; there may be either dry or moist local inflammatory signs.

Group 2. The perianal skin varies but slightly from the normal, showing no visible local changes.

Group 3. The typically chronic or advanced type with thickened or leathery appearance. In this type the normal skin folds are hypertrophied, elongated and inelastic; the sulci are deepened and fissuring is common. Additionally, hyperkeratosis and lichenification are evident.

We routinely advise removal of the existing anorectal pathology early in treatment, as this aids in the restoration of normal physiology. Parasites and fungus infection in the colon and rectum are appropriately dealt with.

Since early 1946, we have been using a medical routine aimed at reducing the pH of the rectal mucosa. This includes an acid-ash diet, glutasin capsules (a form of glutamic acid hydrochloride in combination with pepsin). Gelatin suppositories containng beta-lactose, may be dispensed by any pharmacist. The diet of itself reduces the pH, the glutasin acting as hydrochloric acid when administered orally, aiding in this process. The lactose suppositories tend to prevent the seepage of rectal discharges of a high pH from leaking out during the night.

Local care of the pruritic zone is of paramount important.[18] Following evacuations we advise the use of cotton pledgets or "kleenex", using a boric saturated solution so as to remove any secretions that have accumulated. The area is kept thoroughly dry with boric powder applied on a small piece of cotton which is changed frequently. Mercurochrome is applied to the region each day. We advise against soaps or ordinary toilet paper due to their irritating and traumatizing factors. The frequent association of fungus infection with pruritus must be constantly borne in mind and appropriate local treatment carried out to retard their growth.

Our experiences with this form of treatment lead us to believe it has a definite role in the therapy of pruritus. We are well aware of the fact there still is room for improvement in technic. Most certainly, the skin irritation from an allergic standpoint is difficult to differentiate. Cases not responsive to this therapy are then treated from an allergic tangent as is now being followed by Hayden[17] and his associates at the Massachusetts General Hospital.

We are in accord with Whitney's conclusions[16] in connection with allergic manifestations. Skin tests, elimination diets, and other indirect procedures are, of course, necessary.

Improvement, both symptomatically and pathologically, is evident following the judicious use of the regime above outlined. Many patients are symptom-free in a few days; others may require weeks of persistent treatment which is to be expected especially in the well established cases. Many recurrences and failures are due, unfortunately, to the omission by patients of faithfully carrying out the instructions given them in the manner prescribed.

TABLE 1

Results in Treatment of 125 Cases of Pruritus Ani

Distribution—Male 64—Female 61

Age Incidence—Extremes of age 22 to 65

Greatest Incidence age 30 to 50

Duration—Shortest time ..... 1 month

Longest time ..... 19 years

50 per cent longer than 3 years

TABLE 2

SYMPTOM SEVERITY

Marked—During day	36
During night	125
Increased in relation to bowel movements	37
Increased by nervous upsets	7

TABE 3

SKIN CHANGES

Group 1	55
Group 2	12
Group 3	58

TABLE 4

TREATMENT AND RESULTS

Cases operated for anorectal pathology	107
Cases treated by injection for hemorrhoids or mucosal prolapse	18
Cases showing improvement—3 months or more	37
Cases symptom free—3 months or more	84
Cases not improved	4
Cases showing recurrence during treatment	21
Cases showing allergic manifestations and treated	11
Cases in which definite fungus infection was demonstrated and treated	16
Cases in which parasites—usually pin worms were found	4

COMMENT

The findings in 125 cases of pruritus ani are tabulated. All information cannot be included, but an effort has been made to correlate the significant findings.

It is apparent from table 1, that the incidence of pruritus is about equal between the sexes. Most patients are in the 30 to 50 age bracket. The youngest patient was a female, aged 22, and the eldest, a female, aged 65 years. Duration of the disease prior to admission varied from one month to nineteen years; fifty per cent of the cases exceeded three years duration.

Table 2 records the severity of symptoms. All patients complained of periods of night itching. Thirty-six noted little difference in severity between day and night seizures. For the most part, these patients followed pursuits requiring extended periods of sitting; or they wore tightly fitting clothing. Tight elastic girdles were conspicuous among the female subjects. Thirty-seven had increased itching just prior to or following bowel movements. Seven noted itching as a result of "nervous upsets" attendant on their daily work.

Table 3 groups the cases in accordance with skin changes. Fifty-five in group one showed only inflammatory skin change. In group two, twelve showed no definite skin changes which are frequently associated with anorectal pathology. Group three comprising 58 cases, presented all the typical skin changes relevant to the more advanced cases of pruritus.

Table 4 details the disposition of the cases. One hundred seven were operated on for correction of the anorectal pathology. Eighteen were treated by injection for internal hemorrhoids or mucosal prolapse. In all cases, the patients were placed on the medical regime previously outlined. Thirty-seven showed improvement and are still under observation. Eighty-four are symptom-free and considered cured. Four showed no apparent response to treatment after three months and other types of therapy are in course of trial.

Twenty-one patients showed evidence of recurrence although, in practically every case there had been temporary improvements. Usually the recurrence was due to failure to follow instructions. Return to the correct regime resulted in the patient's becoming asymptomatic. In eleven cases, definite allergic manifestations to food or drugs could be traced. Elimination of the causative allergic factors or treatment with benadryl or vasorin proved helpful.

Fungus infection was demonstrably present in sixteen cases. Addition of the medical regime to the treatment of these cases helped all of them.

The presence of pin-worm in four cases necessitated treatment for their expulsion. This was a major factor in relieving the pruritus.

SUMMARY

1. The hypothesis that anal pruritus is not due to local pathologic changes only but that other causative factors exist has been presented.

2. A review of what is known of the physiologic and biochemical factors relative to pruritus ani has been made.

3. A study of the histopathology is reported in an attempt to show the rationale of treating pruritus ani as a chemical dermatitis.

4. The management of 125 cases of pruritus ani is reported. Particular reference is made correcting the high alkaline pH of the rectum.

5. Improvement both symptomatically and pathologically is evident following the use of the regime described and may be considered a valuable adjunct to the treatment of pruritus ani.

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LECTURES TO THE LAITY

The New York Academy of Medicine again features an all-star bill of popular lectures this winter. These talks will be given on the following Wednesday evenings at the Academy, 2 East 103rd Street, New York, at 8:30 p. m.

December 17: *Food and Civilization.* Sir Raphael Cilento, Commissioner of Health, State of Queensland (Australia).

January 22: *On Being Old Too Young.* Edward J. Stieglitz, M.D., Chief of Staff, Suburban Hospital, Washington, D. C.

February 4: *Perspectives in Cancer Research.* Cornelius P. Rhoads, M.D., Director, Memorial Hospital, New York.

February 26: *Psychiatry for Everyday Needs.* William C. Menninger, M.D., President-elect, American Psychiatric Association.

March 11: *Pure and Applied Science As Applied to Medicine.* James B. Conant, Ph.D., President, Harvard University.

SEMINAR ON PHYSICAL MEDICINE

An instructive and interesting seminar on physical medicine has been announced for the week beginning December 1, 1947. The seminar will include lectures, demonstrations and opportunities for questions and discussion from the floor. All meetings will be held at the New York Polyclinic Hospital, 345 West 50 Street. New York 19, N. Y., and a detailed program is available for physicians who write to Dr. Richard Kovacs at that hospital.

ACADEMY OF DERMATOLOGY AND SYPHILOLOGY

The next annual meeting of the American Academy of Dermatology and Syphilology will be held at Chicago, December 6 to 11, 1948. An intensive graduate course in pathology and mycology will be held concurrently with the convention. There will also be teaching clinics at the University of Illinois. Dr. Earl D. Osborne, 471 Delaware Avenue, Buffalo, N. Y., will send a detailed program to any physician who requests it.

BENIGN PAROXYSMAL PERITONITIS
(REPORT OF TWO CASES)

T. S. Heineken, M.D., Bloomfield, N. J.

Soon after Osler [1] in 1895 reported the occurrence of severe gastro-intestinal symptoms (visceral crisis) in several patients with urticaria, angioneurotic edema and purpura, similar cases were reported. Since 1930, many articles have appeared, including those by Rowe,[2] Cooke,[3] and Vaughan.[4] In 1941 Andresen [5] published an excellent evaluation of gastro-intestinal manifestations attributed to allergy. In 1945, Siegel [6] presented a gastro-intestinal syndrome called *benign paroxysmal peritonitis* which he believed to be on an allergic basis. He suggested this designation until the time when it could be placed on a sound etiologic and pathologic basis.

This syndrome is characterized by recurrent paroxysms of severe abdominal pains with fever, marked malaise, intense nausea and vomiting during an attack. Between attacks the patient remains in good health without any persistent anatomic lesion. Involvement of the peritoneum is indicated by the marked abdominal soreness and by findings of widespread, exquisite direct and rebound tenderness.

THE CLINICAL SYNDROME

This disorder usually occurs in the second or third decade but may develop later. It may be found in women but usually occurs in men. At first, the attacks may only occur once or twice a year and subside rapidly. In later life the attacks may become more frequent and last longer.

One of the essential symptoms is abdominal pain, which may be diffuse and cramplike or may be localized in the lower or upper abdomen. Rebound tenderness is always elicited, indicative of the underlying peritoneal irritation. It is, at first, localized (most often in the lower abdomen). Later these signs become generalized and may persist for more than twenty-four hours. Abdominal soreness persists for two or three days with moderate abdominal distention.

General prostration and malaise and later profound exhaustion may be present with nausea and vomiting. During an attack as much as ten pounds of weight may be lost but quickly regained unless seizures occur too frequently.

Urticarial wheals might occur in a major paroxysm but are considered rare as are other vascular skin lesions.

Hematologic tests will occasionally reveal a leucocytosis and polynucleosis but a normal count is the rule. Eosinophilia is not found.

Allergic studies may or may not find the cause of the disturbance, but a history of allergy is usually elicited.

Adenopathy was noted in the two cases observed by the author which are presented in clinical abstract.

CASE ONE

A 54 year old male stated that his illness began eight years ago with several attacks of abdominal pain accompanied by fever. These pains were steady and dull, occurring in the right or left lower quadrant. Each episode was febrile, the patient being acutely ill, prostrated and incapacitated for at least forty-eight hours. He consulted various doctors, received numerous colonic irrigations, followed many diets and took all kinds of medication, without relief. He was finally placed on a high protein diet, which consisted of steaks with each meal. A diagnosis of food allergy with spastic colon was made. No allergy tests were made but x-rays of upper gastro-intestinal tract, gall-bladder, and colon failed to reveal structural disease. He continued on this diet (until meat was rationed) without an attack. During the war he was, of course, unable to follow the diet and had a return of his symptoms.

He was first seen by me in December 1945 in consultation. At that time he was lying uncomfortably in bed with dull lower quadrant pain. His temperature was 99.2 by mouth, pulse 68 and blood pressure normal. Examination of the abdomen revealed slight distention. On palpation, I elicited deep tenderness along the descending colon and rebound tenderness in the right and left lower quadrants. Rectal examination was negative; the prostate was not tender. Bilateral inguinal nodes were noted. The following day, his temperature was normal but the rebound tenderness in the left lower quadrant was still present. He stated he

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had been passing mucus in his stools. Two days later, I passed a sigmoidoscope to eighteen centimeters. At that point, spasm prevented further investigation. The mucous membrane was of rose velvet appearance with occasional small submucosal bleeding areas (no ulcers were found). Mucus was present in the sigmoidal washings. With anti-spasmotics and a restricted diet for forty-eight hours, he was entirely free of pain or rebound tenderness. He has had two recurrent attacks since 1945 and on examination, the rebound tenderness, temperature, prostration and adenopathy have been found.

CASE TWO

This 34 year old female complained of fatigue, general weakness, dull pains in the epigastrium and cramp-like pains in the lower quadrants. The pains in the epigastrium radiated to the left and the sharp cramp-like pains radiated through to the lumbar region. These attacks had occurred off and on for the past seven years and seemed to be more severe two to three hours after meals. Nausea and vomiting were present and she was unable to eat because of these symptoms. At the time of the attacks she would have a temperature of 99 to 101 degrees. The bowel movements alternated between constipation and diarrhea. With the diarrhea, she had cramp-like pains in the lower abdomen and after a bowel movement the pains were less severe. She had lost as much as 10 pounds during an attack. Within the past year her attacks had been more severe and occurred weekly, lasting for two or three days. She had been examined by an allergist and found sensitive to house dust, soap powder, lye, moth spray and paint odors. The following foods gave a reaction: chicken, wheat, cauliflower, cucumbers, pickles, chocolate, cocoa and bananas. She also showed reactions to grass pollens.

About five years ago an exploratory operation was performed because of the severe abdominal pain. The gall-bladder was normal and not excised. A "chronic appendix" was removed, but she continued to have pain.

Sigmoidoscopic examination showed the rectal mucosa to be slightly hyperemic. The instrument was passed full length with slight spasm. Mucous membrane in the sigmoid was pale, thin-walled, with blood vessels standing out clearly beneath the mucous layer. Slight mucus was found in the sigmoid washings. Culture showed Eschericia coli and Bacillus subtilis.

She was advised to go on an elimination diet and after following this diet with anti-histaminetics has been able to resume a teaching position. There are still occasions when she will have mild attacks with fever, but none as severe as before.

SUMMARY

Two cases are presented similar to benign paroxysmal peritonitis as described by Sheppard Siegel [6] with an unusual syndrome consisting of intense abdominal pains and fever. The presence of adenopathy has been noted in these cases. Etiology has been suggested as well as treatment with elimination diets and anti-histaminetic substances.

17 Park Place

THE NEW JERSEY NEUROPSYCHIATRIC ASSOCIATION

announces

THE C. C. BELING MEMORIAL LECTURE

DATE — WEDNESDAY, NOVEMBER 19, 1947, at 8:30 P. M.

Place — Academy of Medicine, 91 Lincoln Park, Newark

Speaker

Harrison S. Martland, M.D., Chief Medical Examiner of Essex County

Subject—**VIRUS ENCEPHALITIS**

All physicians are invited to attend this meeting and hear this original presentation of a new and increasingly important subject.

ROLE OF THE PRIVATE PRACTITIONER IN VENEREAL DISEASE CASE FINDING*

William A. Brumfield, M.D., Albany, N. Y.

Case finding in venereal disease may be considered under three headings: (1) Education of the public, (2) Mass serologic tests of various selected population groups, and (3) The follow-up of contacts with persons known to be suffering from venereal disease.

It may be surprising to know that the proportion of positive examinations for syphilis discovered by private physicians in office studies of patients is higher than any of those obtained through routine examinations of large population groups. Obviously then, the private practitioner plays a major role in venereal disease case finding. He is also invaluable in the follow-up of contacts and sources of infection. Basically this is a simple procedure. It involves only questioning the patient to determine the identity of the sexual contact prior to the onset of his disease and of those whom he may have exposed subsequent to his infection, and then investigating the individuals identified by the patient to see that they are brought in for diagnostic examination and for treatment, if necessary. As a matter of fact, the elicitation of information regarding contacts of cases of venereal disease is much simpler than almost any other communicable disease epidemiologic investigation. Here the very nature of the contact is such that only a few individuals are suspected and the patient himself can remember these persons, whereas the casual contacts giving rise to other communicable diseases may be completely forgotten.

The attending physician is in the best position to elicit contact information from venereal disease patients, and I say that, despite the fact that in most clinics the public health nurse or the social worker, questions the patients. The interviewer must have the patient's confidence, or he will be unable to persuade him to divulge the identity of his sexual contacts. The private physician has the patient's confidence, or the patient would not have come to him in the first place. Furthermore, the physician can offer a definite service to the patient in return for this cooperation. He can readily explain why it is in the patient's interest (as well as in the interest of the public health) that the information be divulged, and he can assure the patient that the follow-up will be made confidentially and without embarrassment to the contacts or to the patient. The public health nurse or the social worker, on the other hand, may give the patient the same assurances, but their relationships to the patient are such that they have no tangible service to offer, and under these circumstances confidence is much more difficult to achieve.

Tact and patience are required. Some individuals are more successful than others in ferreting out the desired information, but we have not been able to determine what those personal qualifications are or to know why it is that one individual can obtain information from a patient when another person can't. The amount of information obtainable from a patient decreases rapidly as the length of his infection increases. For example, we can get information much more readily from the patient with active signs or lesions of early syphilis than we can from the patient with an early latency, and so on. The patient with early lesions is usually more cooperative than the asymptomatic patient. There again he has something which is disturbing him, and that can be the starting point in the contact follow-up.

Beyond these points it has been impossible to devise any scheme which can be applied universally with equal results in obtaining information from patients. There are those who believe that contact interviews should be made at the patient's first visit, and others will tell you that the interview should be delayed until the patient has overcome the shock

* Read by invitation to the General Session of The Medical Society of New Jersey, April 22, 1947. Dr. Brumfield is Director of Syphilis Control, for the New York State Department of Health, but the views here expressed are offered as those of the speaker, not necessarily those of the Department.

of being informed that he has a venereal infection. In the meantime he also becomes accustomed to the surroundings, and he is less likely to cooperate than if you perhaps "catch him by surprise," so to speak. My own feeling is that it does not make any difference when you undertake contact follow-up activities, whether it is at the first visit or at a subsequent one. The physician must work out his own technic, and if he spends enough time with it, he can work out a satisfactory method of getting the information. The important thing is not to stop until every avenue of approach has been explored and until one is satisfied that the patient is truthful when he says that he can give no more information.

Most patients will deny sexual exposure when first questioned regarding contacts. They will tell you that they got syphilis from a toilet seat or that they got it from glassware, a drinking cup, and so on. The physician should accept the denial of his patient only as a challenge. I have found in my practice a few guides which may be helpful to those inexperienced in contact interviews, and I shall simply hand them on to you in the hope that you may find them useful in your contact interviews.

First, the interview should be as informal and matter of fact as possible. I have made it a routine part of history taking, and carry the conversation over into the physical examination of the patient. While you are examining your patient you have to talk to him about something, and you can just as well talk to him about that. Furthermore, in relating his contact questioning to his physical condition, there is an appeal to the patient which will break down the barrier and persuade him to give you information regarding sexual contacts.

Second, I have found that patients generally may be classified in three groups, to each of which an appropriate approach can be found. First are those patients whose contacts are their close friends or acquaintances whom they wish to shield from embarrassment. Second are those patients who feel resentful at having acquired venereal disease and would like to see their contacts drawn and quartered. Third are the patients whose contacts comprise pick-ups or prostitutes or casual acquaintances whose names are unknown and about whom they are not in the least concerned.

The appeal to the first group should be directed to their sense of chivalry. They will tell you, "I don't like to give you the name of this person because she is a very good friend of mine, and I don't want to get her into trouble." It may be pointed out that the refusal to divulge the identities of these contacts is unfair to the contacts themselves; that it is a false sense of chivalry; that these persons may have syphilis or gonorrhea and be unaware of it; and that they may suffer serious consequences as well as endanger others unless they are treated. Not infrequently this is sufficient to get the patient to give you the names of his contacts. It is always made clear to the patient that his identity will not be divulged in any investigation and that the contact investigation will be carried out confidentially and without embarrassment to his friends whom he names.

The approach to the second or vindictive group, is easy. The patient will gladly name those contacts against whom he feels vindictiveness, which of course should not affect the subsequent confidential investigation of the persons so named. Remember that an individual's friends may be involved in this affair as well as those persons for whom he feels enmity. It is essential not to stop with the names of those people whom he mentions to you voluntarily, but to question him closely to see if he is trying to shield someone else.

The third group of patients embraces those who have their contacts through pick-ups, prostitutes or casual acquaintances. These patients usually express a desire to cooperate, but they deny the knowledge which would be helpful in identifying their contacts. However, it is often possible to obtain sufficient information upon which to base a successful investigation by eliciting data relative to nicknames or physical characteristics of the contacts concerned, the circumstances and the place of meeting of these individuals, and the place of exposure. Occasionally meager data

lead to the discovery of highly promiscuous persons who qualitatively are important spreaders of venereal disease. We have seen instances; for example, a girl named Mary, twenty-four years old, apparently, picked up on the corner of 42nd and Broadway, who went with the patient to a hotel in the vicinity, has been picked up just on the basis of that information. I have also had instances, particularly when I was in the Army in France, when a soldier might give me a photograph of the mademoiselle in question, and on the basis of that photograph we could go out and pick up the girl from the street and take her in for examination. That happens sometimes in general practice as well.

Penicillin has made contact follow-up more important than ever before. During the arsenical heavy metal therapy period, which apparently is rapidly coming to a close, the approach to the patient was directed toward his desire or willingness to protect others. It is not rare now, however, to find penicillin-treated patients reinfected by their original source. We have seen this in several instances, particularly in the case of marital partners. One will acquire syphilis and give it to his spouse. In the meantime, he will be treated. Then the partner may give it back to him when he returns, and eventually she becomes treated. They succeed in passing the infection back and forth between them. This may be called "ping-pong syphilis". That sort of thing can be stopped only by treating both individuals at the same time. So, with penicillin therapy, it is very important not only in terms of public health, but from the standpoint of the patient in the office, to obtain all the information you can regarding his contacts to prevent him from being reinfected by the same individual. It is no longer necessary to appeal to the patient's altruism.

I think we may anticipate a marked reduction in the cost of penicillin, and the development of better vehicles for the drug which will bring it within the means of the lower economic group and convenient for use by the practicing physician in his office. When this comes about, venereal disease control will depend even more upon the private physician's participation in the case finding program. In the not too distant future many of our present venereal disease clinics will be abolished and private physicians will assume responsibility for the treatment of the great majority, if not practically all of venereal disease cases.

The private physician is not greatly concerned with the actual investigations of contacts. In some instances the contacts named by the patient will be known by the physician himself. In this event he can get in touch with the individual named and ask him to report for examination. In most cases, however, he will refer the contacts to the health department for follow-up by trained investigators. In this connection the physician should give the health department investigator all pertinent information possible regarding the contact, although he should not divulge the identity of his patient. Complete cooperation between physician and the health department is essential in order that the investigation may be made promptly, efficiently, and successfully.

The current rise in venereal disease rates focuses attention upon the need for intensive effort in case finding. Since the private physician is treating the majority of infectious cases of venereal disease, his assistance is essential. With his help, there is every reason to believe that its upward trend can be halted and that the eventual eradication of the venereal disease can be accomplished.

State Office Building

CONFERENCE ON OPHTHALMOLOGY

An exceptional program of interest to all ophthalmologists is announced by the National Society for Prevention of Blindness, which will hold its three-day conference in April of 1948. For a detailed program write to that Society at 1790 Broadway, New York 19, N. Y.

CONTROL OF EPIDEMIC DIARRHEA BY DECENTRALIZATION OF INFANTS

I. J. WOLF, M.D., Paterson, N. J.

More than half of the total live births in the United States take place in hospitals. In cities this ratio is very high. In New York City in 1943, for example, 97.3 per cent of all births took place in hospitals. As a result of this high degree of centralization of newborns in nurseries, serious epidemics of diarrhea have occurred. In New York City during the decade ending in 1943, 669 infants [1] died of this condition.

It is the purpose of this paper to call attention to several methods of decentralization of newborn infants as a means of preventing these outbreaks.

HOME DELIVERIES

More uncomplicated obstetrical cases may be delivered at home. Bakwin [1] has pointed out that increasing hospitalization of mothers has *not* lowered the maternal or neonatal mortality. The experience of the Frontier Nursing Service of Kentucky with 4000 deliveries is exemplary. The large majority of the deliveries (92.7 per cent) were done in poor homes by midwives. The maternal mortality was only 0.75 per thousand births, as compared with 5.6 for the white population of the United States at the same time and 5.2 for the white population of Kentucky.

To facilitate home deliveries local Boards of Health in cooperation with local hospitals could set up obstetrical teams. The expectant mother could call the public health nurse when she went into labor and the private doctor or intern on the case could be summoned to the home at the proper time.

SHORTER HOSPITALIZATION

If a nurse has been engaged for home care of the baby, the newborn could be sent home the following day, and, in uncomplicated cases the mother too. This would put an extra burden on the obstetrician unless the baby were put in a pediatrician's care; but removed from a crowded nursery, the infant would be protected from serious infections.

HOSPITAL DECENTRALIZATION

Hospitals have attempted to protect older infants and children from cross-infection by breaking down their pediatric departments into smaller units. Yet the typical newborn nursery still herds twenty to forty infants together in adjoining bassinets. During the war, conditions were even worse. In emergency, newborns were housed in washbaskets or desk drawers. Schick tells of a visit to a newborn nursery where he found one infant covered with vomitus. When he questioned the nurse, she answered: "Oh, that's all right, that came from the baby in the upper tier."

Various plans for the decentralization of newborn infants in hospitals have been promulgated. After an epidemic of diarrhea at the Long Island College Hospital in Brooklyn in 1937, Weymuller [2] decentralized the nurseries in that institution by breaking them into units of eight bassinets. McLendon and Parks [3] of George Washington University School of Medicine have formulated plans to reduce nurseries to four-bassinet and eight-bassinet units and in addition have planned units in which mother and baby may be housed together. Dunham, Shaffer and MacDonald [4] of the Children's Bureau, have published excellent standard plans for newborn nurseries applicable to 50 to 200-bed hospitals. Their newborn units consist of eight cubicles instead of grouped bassinets. Each cubicle makes it possible to maintain strict isolation technic.

SUMMARY

In recent years the high degree of centralization of newborn infants in hospitals has led to the outbreaks of serious epidemics of infectious diarrhea with an attending high mortality. It is now realized that in addition to such fac-

REFERENCES

1. Bakwin, H.: *New England Journal of Medicine, 232:* 691 (June) 1945.
2. Weymuller, Chas. A.: *Child* 5: 215 (June) 1941; ibid. *J.A.M.A.* 133: 78 (January) 1947.
3. McLendon, P. A., and Parks, J.: *Modern Hospital* 65: 46 (July) 1945.
4. Dunham, E. C.; Shaffer, M., and MacDonald, N. F.: *Hospitals* (April) 1943.

tors as the careful handling of infants, the examination of nurses and physicians as possible carriers of infection, the isolation of suspected cases of diarrhea and the careful supervision of formulae rooms, another factor should be stressed—the decentralization of newborn infants in hospitals. This may be accomplished by encouraging more home deliveries, by sending more babies home soon after delivery, or by the decentralization of nurseries as outlined in this paper. Institutions which are contemplating new building programs should give decentralization plans their careful consideration.

231 East 31st Street

THE PUBLIC HAS A STAKE IN TUBERCULOSIS

There are great benefits to the public in the early diagnosis and cure of tuberculosis. The spread of the disease from persons with positive sputum to their families and friends and the community is avoided, and a health hazard of first importance is controlled. The shorter hospitalization period required for minimal cases means that care is effected at a lower cost. Furthermore these patients often adjust themselves economically, and public expenditures for them and their families are thereby definitely lowered.

The practicing physician is an extremely valuable case-finding agent, since he is in a position to discover a vast number of persons with tuberculosis. Indeed, a large portion of patients see him before anyone else. These opportunities for diagnosis are particularly significant at this time, since war, as always, has increased the incidence of tuberculosis.—Bobrowitz and Dwork, New England Jour. Med., January 1947.

OVERWEIGHT A SERIOUS HEALTH HAZARD

The hazardous effects of overweight were underlined by Brigadier General Hillman and a group of civilian medical investigators who reported on their interpretation of the results of more than 20,000 routine physical examinations in the Army. Overweight associated with hypertension, even if the latter appears transient, was found to be a frequent forerunner of cardiovascular-renal disease. Furthermore, hypertension was twelve times as common among overweight military personnel than among those of normal or subnormal weight. Officers who had to be retired because of renal or cardiovascular disease were overweight four times as often as officers who remained on active duty. (Abstracted from the *Journal of the American Medical Association.*)

IMPAIRED CEREBRAL CONTROL IN DIABETICS

For a small number of patients with diabetes mellitus, control is difficult and minor changes in blood sugar initiate severe reactions. The fault may be instability of the cortical control mechanism. In many cases brain-wave tracings are abnormal; some are indistinguishable from interval patterns of epileptic subjects. Greenblatt, Murray and Root routinely use the encephalogram to detect cortical dysfunction in hyper-reactive diabetic patients.

Manifestations of insulin sensitivity are highly variable. Dizziness, weak spells, transient memory disturbance, aphasia or paresis, temper tantrums, petit mal, convulsions, and unconsciousness were noted in 35 diabetic patients. The incidence of abnormal electroencephalograms was greater in this group than among usual diabetic patients.

Atypical tracings of diabetic patients may be due to repeated deprivation of essential brain foods during hypoglycemia, or to recurrent cerebral edema and petechial hemorrhages sustained during profound hypoglycemia.—New England J. Med. 234.119.

GRANDPA DIED AT NINETY

We have all heard this: "How did we manage to get along before we knew about vitamins and had all of these new fangled notions about food? What was good enough for grandpappy is good enough for me!" The point is this: while grandpappy was living to the ripe old age of ninety, thousands of potential grandpappies were filling small and untimely graves in community churchyards. Many of the health hazards of that day were unrecognized, but this made them no less dangerous. Knowledge releases us from the rule of chance and gives us a rational guide to health and longevity.—Walter Wilkins, surgeon, U.S.P.H.S., in the *Mississippi Doctor.*

THE UNSTABLE COLON *

S. Bernard Kaplan, M.D., Newark, N. J.

The colon is a vegetative organ, and a disturbance in any vegetative organ may be but a sounding board for emotional or psychic disturbances. The symptom-complex of paroxysmal attacks of poorly demarcated abdominal pain, no fever or systemic signs, no relationship between food intake and the pains, accompanied by diarrhea or constipation comprises a definite entity familiar to all who practice gastro-enterology.

The high incidence of functional colonopathies is never anticipated by the general practitioner. As Stengel has said "The internist and general practitioner still labor too greatly under the domination of the school of pathologic anatomy".

Causes of functional disturbances of the colon are multifarious and often baffling. Endocrinopathies, neurogenic factors, dietary deficiencies, vagotonia, bacterial allergies, food allergies, and many other factors have been listed. Any one or a combination of these may be present in a particular patient.

The immediate cause of colonic dysfunction is a derangement of the autonomic nervous system. The colonic neurosis represents, perhaps, the truest example of a civilization disorder. The civilized races suffer most, and rarely do we see it among primitive people of slow habits. It is more common in urban than in rural communities. Hereditary or familial tendency is certainly of significance.

In our series of cases. patients were described as emotional, tense, anxious, conscientious, introspective and neurasthenic. Psychic factors play an important role. Personality studies revealed a generally poor psychiatric heredity. Most patients were of low energy, emotionally apprehensive, passive and egocentric. Attacks occur most often after an emotional upset. These patients do not manifest a good output of energy and are generally lacking in vigor.

In an unselected series of 175 World War II veterans, unstable colon was diagnosed in 115 cases. Forty-five per cent of these men had been discharged as psychoneurotics. The tensions of war and the return to a changed civilian life, (with reminiscences of past battles) contributed to this personal maladjustment. In the general run of office practice of the gastro-enterologist, twenty-two per cent of the patients are thus affected. In a series of fifty children, however, ninety per cent had unstable colons. Male and female were about evenly divided. Many of these children had had appendectomies, and cystoscopies in an effort to find a determining cause for the varied abdominal symptoms.

Too often the roentgenologist has omitted the barium enema in his gastric series and thereby missed the changes in the pattern outline of the colons. Small haustra changes have gone unnoticed.

Symptoms of the individual with unstable colon are many and varied. Discomfort or pain, crampy in type in the lower abdomen was the leading complaint. Attacks may last from minutes to days. The discomfort is described as a dullness or heaviness in the lower abdomen, "as if someone had beaten the abdomen with a stick". Gas, belching and bloating follow the spells. The attacks seldom interfered with sleep and, at times, relief was attained by expulsion of flatus, bowel movement or by enema. Upper abdominal symptoms may accompany bouts of lower abdominal distress. Normal bowel movement may accompany attacks. Constipation is a major complaint though diarrhea occurs frequently. The bowel movement is usually abnormal, either a slightly constipated stool followed by a soft mushy movement, or small hard pellets. Long, narrow stool may be present.

Essential to the management of these patients is a thorough examination. Certainly, examination of the blood and stools, proctoscopic and sigmoidoscopic examination, and the fluoroscopic and roentgenologic study of the colon and terminal ileum represent the minimal amount of study necessary.

* Read by invitation, April 23, 1947, Annual Meeting, The Medical Society of New Jersey.

In the x-ray studies, the barium enema is of utmost importance. Missing the diagnostic value of interpretation of the barium enema has accounted for many diagnostic failures.

TREATMENT

Hospitalization is definitely to be avoided. Most of these patients get worse at the mere mention of a hospital, even though the change in environment and habits may be a start toward readjustment.

Diet in the beginning should be one of a non-residue variety, in an effort to give the colon a much needed rest from any type of irritating residues. Drugs are of value only in minimizing nervous tension or in controlling the more active phases of diarrhea.

Treat the patient, not the bowels. The bowel is basically not at fault; it merely expresses, through its abnormal activity, the patient's inability to carry on.

Results depend largely on the doctor's ability to have complete understanding with the patient. Fears must be dispelled. A cure is possible only to the extent of the patient's response. The condition may return at any time. It is a nuisance or slight handicap, with which one can live and carry on within reasonable limits. Failures and discouragements are many, but enough of these patients are salvaged to bring to the physician some satisfaction for his efforts.

DISCUSSION

DR. I. GELBER (Elizabeth, N. J.): Not once during his talk, has Dr. Kaplan used the word "colitis". For this restraint, he deserves commendation. Usually the patient comes to the gastro-enterologist after he has made an extensive and expensive tour of practitioners throughout the community, and he gravely tells us that his affliction is colitis. With the aid of a dictionary, his natural pessimism and insecurity lead him to the conviction that he has an inflammatory disease, and that some stubborn ailment has gained permanent residence in his bowels. I have tried showing some of my patients, the modern text-books which make it clear that "colitis" is neither inflammatory nor organic. In some measure, I have been rewarded.

The veterans cited by Dr. Kaplan introduce another question. How extensive a diagnostic survey was made on these patients for the purpose of ruling out organic disease? I refer particularly to those who had had acute episodes of bloody diarrhea. Many of these had had positive stools while in the service. We have a problem here both in terms of what we owe these ex-soldiers and sailors with respect to their own welfare, and in terms of the public health questions raised. I am troubled by the monotonously negative x-ray and laboratory reports and routine discharge diagnoses. As a sheer matter of simple statistics we should have had more positive results. To the minimum diagnostic study outlined by Dr. Kaplan, I should add cholecystography, gastric analysis, and (when colonic spasms occur premenstrually) endocrine studies too.

DR. E. MERLISS (Newark, N. J.): The essayist is certainly right in spot-lighting the fact that the cause of irritable colon is in the "make-up" of the patient. In gastro-enterology the physician encounters the worrisome and neurotic individual more often than does the practitioner in other specialties. The frequent outpouring into the tissues of epinephrine, acethylcholin or pitressin stops and races the bowel without any purpose. Remember that the ceco-colic sphincter, the sphincters at the hepatic flexure, proximal transverse colon and at the recto-sigmoid, as well as those of the cardia, pylorus and jejunum have the sympathetic as their motor nerve. One can imagine the state of these sphincters when a huge amount of epinephrine is pumped into them as a result of rage or other emotion. These sphincters may go into violent spasm and bring the motility of the colon to a stop. At the same time, the outpouring of acethylcholin or pitressin may produce a powerful motor influence on the segments of the gut between the sphincters. This chaotic movement of the colon—stopping and racing in the same time—is enough to produce severe symptoms of unstable colon and make the patient miserable. The gastro-enterologist has to find a way to solve the problem of irritable colon. Theoretically, what we need is to reduce the influence of the cerebral cortex upon the hypothalamus. I believe the neuropathic patient should be sent to a psychiatrist who may find a way of unearthing the cause of his anxieties and help him gain the peace of mind, which is so necessary for the normal function of the autonomic nervous system. Less stubborn cases of irritable colon should be treated by the gastro-enterologist. To be successful we have to borrow from the psychiatrist some of his methods of psychotherapy. We have to put aside a special hour for the case of an irritable colon; we have to be good listeners while trying to acquaint ourselves with the patient's temperament, his hereditary traits, his bringing up and his environmental influences. We have to see clearly the patient's difficulty and understand why the patient reacts to his problem in an "emotional" way. Perhaps the physician can advise his patient how his particular problem could be solved without emotion. Of course, his feeling of insecurity may be resistant to reassurance. Freedom from fear and freedom from want are not around the corner yet. However, many neurotic individuals are eager for advice and they may be taught how to evaluate correctly their own abilities, how to avoid aiming at goals which they can never at-

tain, and how to cut down on ambitions and energy for which they may never find an outlet.

In treating the patient with unstable colon we have to use other methods of psychotherapy, such as the practice of relaxation, the finding of an outlet in social activities, the vocalization of feelings instead of their repression, the cultivating of some avocation and the guest for some recreation. Without all these methods which were practiced and taught thousands of years ago by the old Greek philosophers, we can not be successful in treating the patient with an unstable colon.

31 Lincoln Park

BOOK REVIEWS

Sexual Inadequacy of the Male; a Manual for Counselors. By Paul Popenoe, Sc.D. Pp. 41. (Publication No. 517) Los Angeles, California, The American Institute of Family Relations, 1946.

The manual is a well-written outline of the subject of "Sexual Inadequacy of the Male". It briefly discusses the causes, and suggests the treatment for this condition.

For family counselors this publication can be of great use. It gives them an orderly outline and method of attacking this problem.

After eliminating the pathologic conditions which can cause this ailment, it attacks the subject from a psychologic angle. We know that psychologic factors are most common causes of impotency. The patient should be studied thoroughly in order that one can arrive at the true cause of the so called impotency. This study is a very important force in the maintenance of a happy and normal family life.

The pamphlet seems to touch upon all factors and causes of this social problem. It can be of great help to those engaged in this type of work.

Burnet Rothhouse, M.D.

Medicine in the Changing Order. Report of the New York Academy of Medicine and the Changing Order. The Commonwealth Fund, New York. 1947. 232 Pages. $2.00.

This work represents a critical and exhaustive study of current medical services by 48 committee members—physicians, dentists, nurses and laymen. Their report makes easy and interesting reading.

The Committee has painstakingly reviewed medical history in tracing the origins of present problems in American Medicine. The reader will find a wide variety of related subjects included in the discussion. Topics deserving special mention are: medical care in rural areas, extension of public health services, the quality of medical care, nursing, medical insurance—voluntary and compulsory.

In pointing a way toward the improvement of medical services, the Committee stresses need for cooperation of physicians in the organization of health centers for curative and preventive medicine and the need for voluntary medical insurance plans.

The medical problems are viewed in the light of present-day living and not as isolated phenomena.

It behooves every physician to take time out to study the subject matter of this important report.

Leonid S. Snegireff, M.D.

Office Immunology Including Allergy; a Guide for the Practitioner. Ed. by Marion B. Sulzberger, M.D., and Rulolph L. Baer, M.D. Pp. 409 with 26 tables and 14 photographs. Chicago, Year Book Publishers, Inc., 1947. $6.50.

This book presents office procedures useful to the practitioner faced by problems in allergy, dermatology and infectious disease. Its valuable tables, photographs and listings should make the procedures easily understood.

No claims are made for pollen, patch and protein skin testing which are not sober and in accordance with the known facts. Too frequently the reports are at variance with results obtainable in the office. Thus the cycle of enthusiasm for protein and patch-testing has subsided to allow a fair appraisal to be made.

A practical point the authors make is the careful listing of biologicals and the drug houses supplying them. This is a convenience of great value. As a new book in the field it may be heartily endorsed for both the general practitioner and the student.

Irving Shapiro, M.D.

Pharmacopoeia of the United States of America (The United States Pharmacopoeia XIII). By authority of the United States Pharmacopoeial Convention meeting at Washington, D. C., May 14 and 15, 1940. Prepared by the Committee of Revision and published by the Board of Trustees. 13th revision. Official from April 1, 1947. Pp. 958. Easton, Pa., Mack Printing Co., 1947.

Another milestone in American medical history was landmarked by the release in April of the thirteenth U. S. Pharmacopoeia. From its cherry red cover to its table of molecular weights, this new bible of drug therapy is a thoroughly revised volume. For the first time in history, the English titles appear first and determine the alphabetical arrangement. Derivative drugs are grouped with the basic preparation—another innovation, and a sensible one. Dosages are given now in rounded metric units, and a quick reference conversion table is printed inside the back cover. Ninety-five new drugs have been included in USP XIII. Spanish titles as well as Latin names are given for all drugs. The section on testing and assaying of drugs has been rewritten and extended. USP XIII on a doctor's book shelf stamps him as an up-to-the-minute practitioner.

Gilbert Shoger, M.D.

STATE ACTIVITIES

BOARD OF TRUSTEES

SEPTEMBER 28, 1947

The regular meeting of the Board of Trustees was held September 28; 1947, in Trenton.

Those present were: Dr. Crowe, Chairman, who presided; Dr. Sica, Dr. Hawkes, Dr. Fithian, Dr. Coleman, Dr. Norton, Dr. Allman, Dr. Lance, Dr. Johnsen, Dr. Green, Dr. Schaaf, Dr. Hornberger. Drs. Lee, Costello, and Scammell were excused because of illness; Dr. Young and Dr. Wood, on vacation. Also present upon invitation were Drs. Londrigan, Scott, Yaguda, Wuester, Murray and Barkhorn; Mr. Bryan and Mrs. Madden.

CANCER CONTROL PROGRAM

The Advisory Committee on Cancer Control recommended approval of the Mountainside Hospital Plan following the principles outlined in a letter to President Schaaf, dated September 26, from Dr. J. S. Lincoln:

1. Fee for those who can afford to pay to be $10.00 which is to include three blood tests; $5.00 of this fee to go to the examining physician.
2. Indigents will be interviewed by hospital social worker and examined without fee by the medical staff. Indigents may make such contribution as they can afford.
3. Private patients may report to the clinic without referral providing they reside in the area served by this hospital. (This arrangement is satisfactory to the Essex County Medical Society for one year after commencement of service.)

The Committee also recommends approval of:

1. That exact financial arrangements be arrived at by the Essex County Cancer Committee, the State Cancer Committee, and the Medical Director, New Jersey Division, American Cancer Society.
2. That no action in approving the above shall violate any rules or regulations regarding the disbursement of funds laid down by the American Cancer Society Finance Committee or its auditors.

On motion, seconded and unanimously carried, the recommendations were approved.

The following resolution which was approved in part by the House of Delegates, 1943, (from the Public Relations Committee Annual Report), was adopted upon motion by Dr. Schaaf, seconded by Dr. Sica and unanimously carried.

Be it resolved (1) That The Medical Society of New Jersey reaffirm its adherence to the principle that medical care be made available to everyone at a cost which he can afford to pay; (2) that we recognize our responsibility for the medical care of the indigent and medically indigent group; (3) that we do not seek payment for the care of needy patients except for special categories of beneficiaries for whom government funds have been made available by specific appropriation (E.M.I.C. —Veterans— Old Age—etc.) (4) that we do not make pressure upon private organizations such as the American Cancer Society to assume the burden of payment to the physician for the care of the indigent and medically indigent group; (5) nothing in this resolution shall be interpreted as indicating the abandonment of our efforts to attain the establishment of a system for the payment for the medical care of the indigent and medically indigent groups by subsidy from tax funds on a municipal, county or state level.

The Cancer Committee does not favor the establishment of terminal care homes, but thinks existing hospital facilities should be enlarged and augmented, if necessary, to care for this type of patient, and requested guidance from the Board.

Upon motion by Dr. Schaaf, seconded by Dr. Fithian and unanimously carried, the problem of terminal care of the cancer patient was referred to Dr. Scott's Committee on Medical Care.

The Board of Trustees unanimously extended a vote of thanks to Dr. Wuester and his Cancer Committee for their excellent work.

VETERANS LIAISON COMMITTEE

Upon motion by Dr. Schaaf, seconded by Dr. Sica, the report of the Veterans Liaison Committee was received.

Dr. Londrigan reported that the Liaison Officer between the Medical Society and VA is one of the greatest assets of the Committee and of the operation of the program in the State. While the Washington office of VA is favorable to New Jersey's Liaison Officer, the Regional Office of VA in Philadelphia wants the office abandoned.

Upon motion by Dr. Schaaf, seconded by Dr. Lance and unanimously carried, the matter of the Liaison Officer for Veterans Administration was left in the hands of the Central Veterans Liaison Committee and the

Medical Service Administration with power to act; final decision on signing the new contract left to these two groups.

ANNUAL MEETING—1948

Dr. Harrold A. Murray, Chairman of the Annual Meeting Committee, presented a skeleton program of the 182nd Annual Meeting—April 26-29, Haddon Hall, Atlantic City, which was approved.

ANNUAL MEETING DATES AND PLACE—1949

Dr. Murray announced that the only available dates for our 1949 Annual Meeting at Haddon Hall were May 16-19, 1949. These dates are impractical because the A.M.A. will meet in Atlantic City the first week in June, 1949. Other Atlantic City hotels have been investigated and the Ambassador has offered the dates of April 25-28, 1949.

Upon motion by Dr. Allman, seconded by Dr. Norton and carried, the Trustees approved holding the 1949 Annual Meeting at the Ambassador, Atlantic City, April 25-28, 1949.

FOUR-DAY ANNUAL MEETING

Upon motion by Dr. Schaaf, seconded by Dr. Norton and unanimously carried, the Trustees validated the extension of the annual meeting to a four-day session — which advances the first meeting of the House of Delegates from Tuesday to Monday and provides time on the program for the seven new sections.

REPORT OF THE PRESIDENT

Appointment of Executive Officer — Dr. Schaaf moved that the Trustees validate the employment of Mr. James E. Bryan as Executive Officer of the Society, salary $12,000, term of office one year, beginning September 1, 1947. Motion was seconded by Dr. Norton and unanimously carried.

Executive Officer Committee Discharged—Upon motion by Dr. Schaaf, seconded by Dr. Allman and unanimously carried, the Committee appointed for the purpose of securing an Executive Officer for the Society was discharged with thanks.

Titles of Salaried Personnel — Dr. Schaaf moved that Mrs. Edith L. Madden be designated as Executive Assistant and Convention Manager. Motion was seconded by Dr. Sica and unanimously carried.

Dr. Schaaf moved that Dr. Norman M. Scott be designated as Medical Director, Distribution of Medical Care. Motion was seconded by Dr. Allman and unanimously carried.

Attendance at A.M.A. Meetings — Dr. Schaaf moved that the Executive Officer be authorized to attend all sessions of the House of Delegates of the A.M.A. and other A.M.A. meetings (Secretaries, Editors' Conferences, etc.). Motion was seconded and unanimously carried.

Upon motion by Dr. Schaaf, seconded and unanimously carried, Dr. Scott was authorized to attend the November meeting of the A.M.A. in Chicago—Conference on Medical Care and Veterans Plans followed by the Secretaries and Editors Conference, and as recommended by the Welfare Committee, to accompany the New Jersey Delegates to the A.M.A. House of Delegates with all expenses paid.

Joint Committee of Physicians and Dentists—In conformity with a proposal from the A.M.A. that each State Society establish a Committee to be known as the Professional Relationship Committee of Physicians and Dentists, Dr. Schaaf moved that the Board authorize such a Committee; medical members to be appointed by the Chairman. Motion was seconded by Dr. Coleman and unanimously carried.

Sister Elizabeth Kenny Foundation — A communication addressed to a member of the Board from the Chairman of the New Jersey Sister Kenny Fund, requesting him to accept honorary membership in the Kenny organization and to lend his support in their drive for funds was read. Since this organization would be overlapping the already existing National Foundation for Infantile Paralysis, the Board, upon motion, regularly seconded and unanimously carried, disapproved the proposal to establish a Sister Elizabeth Kenny Foundation in New Jersey, with separate hospitals.

Consolidation of New Jersey Health Units —The Board discussed the reorganization of local health jurisdictions and their consolidation into a smaller number, to integrate the health services within the new areas under full-time professional health direction, and ultimately tie in with the program of the State Department of Institutions and Agencies for health centers under the Hill-Burton Act.

Upon motion by Dr. Schaaf, seconded by Dr. Johnsen and unanimously carried, the Board endorsed in principle the idea of consolidation of the health units in the State.

Letters to Drs. Lee, Costello and Scammell —Dr. Schaaf reported that Drs. Lee. Costello and Scammell were unable to attend today's meeting because of illness. He moved that the Secretary send letters of encouragement to each. Motion was seconded by Dr. Sica and unanimously carried.

American Diabetic Association—The American Diabetic Association wishes to circularize the physicians of New Jersey on its program of public education and requested endorsement of its organization, and its New Jersey Chapter.

Upon motion by Dr. Schaaf, seconded and unanimously carried, the Board endorsed the American Diabetic Association and its New Jersey Chapter.

A.M.A. Award — General Practitioner — The September 13 issue of the J.A.M.A. carries an announcement of the establishment of a special annual award to give greater recognition to the status and services of general practitioners. The first award will be conferred during the next meeting of the A.M.A. in Cleveland.

The name of one New Jersey candidate for the award has been submitted.

Dr. Schaaf moved that this nomination be received and all county societies be invited to send in similar recommendations. Motion was seconded by Dr. Norton and unanimously carried.

New Jersey Award — General Practitioner —Dr. Hawkes suggested that a similar award be established in New Jersey and moved that the State Society establish an annual award for the most distinguished general practitioner of medicine in the State of New Jersey; all component societies to be solicited for recommendations for the award; that the Chairman of the Board appoint a Committee to pass on the nominations for the award—the award to be selected by the Committee subject to the final approval of the Trustees. Motion was seconded by Dr. Johnsen and unanimously carried.

Advisory Health Council—President Schaaf reported that the Special Committee to make recommendations to the Governor for appointments to the Advisory Health Council has submitted the following names: Dr. C. Byron Blaisdell, Long Branch; Dr. Samuel Blaugrund, Trenton; Dr. Marcus W. Newcomb, Browns Mills; Dr. George W. Fithian, Perth Amboy; Dr. Arthur B. Peacock, Moorestown; Dr. Ellen C. Potter, Trenton; Dr. Stanley Nichols, Long Branch; and Dr. Henry C. Barkhorn, Newark.

The following physicians were appointed to the Council by Governor Driscoll: Dr. Marcus W. Newcomb, Browns Mills; Dr. Frederick P. Lee, Paterson; and Dr. Walter G. Alexander, Orange.

School Health Units — The proposal to establish in each county a school health unit consisting of school physicians, nurses, dentists, psychiatrists and others has the endorsement of the State Department of Education. It is requested that this project be assigned to the Woman's Auxiliary for execution.

Dr. Schaaf moved that this project be referred to the Woman's Auxiliary for implementation, contingent upon approval by the School Health Committee. Motion was seconded and unanimously carried.

STUDY OF MEDICAL CARE

Dr. Scott, Chairman of the Special Committee on the Study of Medical Care, read a communication from Thomas A. Hendricks, Secretary of the Council on Medical Service, A.M.A., requesting the "ideas, suggestions and cooperation of The Medical Society of New Jersey as to how best the National Health Program can be carried out on a national scale".

Upon motion by Dr. Schaaf, seconded by Dr. Johnsen and unanimously carried, the Trustees concurred in the request of Mr. Hendricks that The Medical Society of New Jersey cooperate with the A.M.A. in the evolution of principles of a national health program.

PHYSICIANS' FEES—STATE AGENCIES

Dr. Lance, Chairman of the Special Committee, presented the following report for approval:

Old Age Assistance—The Committee recommends that Medical Service Administration be requested to study this problem and set up a state-wide plan for control of the payment for services.

Board of Child Welfare—The Committee recommends that the Medical Service Administration be requested to study this problem and set up a state-wide plan for control of the payment for services.

Crippled Children's Commission — a. The Committee recommends that some remuneration be paid by the Crippled Children's Commission to physicians doing work for the Commission.

b. We further recommend that Medical Service Administration study the problem with a view to setting up a plan similar to the plan now operated for the City of Newark.

Hospital Service Plan Contracts—a. The Committee believes that the present Hospital Service Plan contracts violate the provisions of the Medical Practice Act.

b. The Committee recommends that Medical-Surgical Plan explore the possibility of removing payment for services of roentgenologists, pathologists, anesthesiologists and physical therapists from the contracts of the Hospital Service Plan and transfer the responsibility for the payment of such services to the contracts of the Medical-Surgical Plan.

The above recommendations were approved upon motion.

Upon motion, seconded and carried, the Special Committee was discharged with thanks.

SPECIAL COMMITTEES

Intern Training — Upon motion, seconded and carried, the members of the Intern Training Committee were reappointed for 1947-48:

Dr. Charles H. Schlichter, Chairman
Dr. John N. Connell
Dr. Henry B. Decker
Dr. Richard H. Deiffenbach
Dr. Arturo R. Casilli

House Committee—Upon motion, seconded and carried, the members of the House Committee were reappointed for 1947-48:

Dr. L. Samuel Sica, Chairman
Dr. David B. Allman
Dr. Royal A. Schaaf

Inter-Professional Relationships — Private Hospitals—It was recommended that these two Special Committees be combined. Upon motion, seconded and carried, the Chairman was authorized to appoint the members of the new Committee after study.

Insurance Committee — Upon motion, seconded and carried, the Committee was discharged with a vote of thanks.

Osteopathic Problems — Upon motion, seconded and carried, the Committee was discharged with a vote of thanks.

REAPPOINTMENT OF SALARIED PERSONNEL

It was recommended that reappointment of the following salaried personnel be validated as of June 1, 1947, for terms of one year at salaries approved by the House of Delegates, April 29, 1947:

Dr. Frederic J. Quigley, Executive Secretary, Subcommittee on Legislation, salary $5,000, plus existing expense arrangements.

Upon motion by Dr. Schaaf, seconded by Dr. Johnsen and unanimously carried, the recommendation was approved.

Dr. Henry A. Davidson, Editor, salary $1,200, plus traveling expenses.

Upon motion by Dr. Schaaf, seconded by Dr. Norton and unanimously carried, the recommendation was approved.

Dr. Norman M. Scott, Medical Director, Distribution of Medical Care, on full time loan to Medical Service Administration, salary $4,000.

Upon motion by Dr. Schaaf, seconded by Dr. Johnsen and unanimously carried, the recommendation was approved.

AUDIT COMMITTEE

Upon motion by Dr. Schaaf, seconded by Dr. Sica and unanimously carried, the Chairman was authorized to appoint a committee of three, who are not members of the Finance and Budget Committee, to review the 1946-47 audit as prepared by J. S. Teunon and Co. Dr. Crowe appointed the following:

Dr. Joseph G. Coleman, Chairman
Dr. George W. Fithian
Dr. Sigurd W. Johnsen

RECOMMENDATIONS OF THE WELFARE COMMITTEE

The following recommendations of the Welfare Committee, which met on September 14, 1947, were presented to the Board for approval:

1. That the paper delivered by Marjorie Shearon, Ph.D., titled "Federal Propaganda for the Welfare State", be published in THE JOURNAL either in its entirety or in abstract thereof.

Upon motion by Dr. Schaaf, seconded by Dr. Lance and unanimously carried, the recommendation was approved.*

2. *Legislation.*

That the Legislative Committee receive specific directions for vigorous opposition to possible legislation for the licensing of graduates of substandard medical schools, if such bills are introduced at the forthcoming session of the Legislature.

Dr. Schaaf moved the approval of this recommendation and that the Legislative Committee be so directed. Seconded by Dr. Johnsen and unanimously carried.

3. *Medical Practice.*

a. Upon motion the resolution from the Advisory Committee on Clinical Pathology was tabled.

b. That the opinion of The Medical Society of New Jersey on hospitals requesting physicians to contribute voluntarily, or otherwise proffer a fee for each hospital admission to help the hospitals financially, be one of disapproval; the New Jersey Hospital Association and all New Jersey hospitals to be informed of our disapproval of this type of tax.

Upon motion by Dr. Schaaf, seconded by Dr. Johnsen and unanimously carried, the opinion expressed in the recommendation was approved.

c. Definition of a Public Health Center.

Upon motion by Dr. Schaaf, seconded by

* In compliance with this instruction, an extensive abstract of the paper was published in the October JOURNAL, pages 413 to 418.

Dr. Coleman and unanimously carried, approval of the definition was tabled pending further study.

4. Public Health.

a. Venereal Disease Control.

Dr. Schaaf moved that the two recommendations on Venereal Disease Control be tabled and referred to the Committee on Inter-Professional Relationships to discuss with the New Jersey Pharmaceutical Association. Motion seconded by Dr. Sica and unanimously carried.

b. Public Health Education as a part of college entrance requirements.

Dr. Schaaf moved this recommendation be tabled for further study; seconded and unanimously carried.

5. Public Relations.

The program of the Subcommittee on Public Relations was approved.

FINANCE AND BUDGET COMMITTEE

Dr. Allman, Chairman, submitted the following supplementary budget allotments as approved by the Finance and Budget Committee:

C-5—Public Relations Committee	$5,000.00
A-4—Executive Travel	500.00
A-3—Executive Office Expenses	800.00
D-8—Woman's Auxiliary (to be made available for public relations; to be distributed through the Executive Offices when and if the need warrants)	1,000.00
Contribution to New Jersey Formulary Research Foundation	500.00
Total to be transferred from Surplus	$7,800.00

The Committee also recommends that the salary, office expenses, travel, etc., of the Executive Officer incurred in carrying out his assigned duties in the public relations field be charged to Administrative accounts.

Upon motion by Dr. Allman, the supplementary budget allotments and the recommendation re allocation of expenses were approved.

HOSPITAL MANUAL

In discussion, objections to individual sections of the Manual were made and it was the consensus that these differences should be reconciled before granting approval.

Upon motion by Dr. Schaaf, seconded by Dr. Norton and carried, the Manual was referred to the Special Committee of the Welfare Committee for study and report to the Board of Trustees, at a special meeting if necessary.

Upon motion, seconded and unanimously carried, the meeting was adjourned at 4:25 p. m.

DAVID W. GREEN, M.D.
Secretary.

HOSPITAL AND PUBLIC HEALTH RESOURCES IN NEW JERSEY

Under the terms of the Federal Hospital Survey and Construction Act (popularly known as the "Hill-Burton Act") the Department of Institutions and Agencies was designated as the "single state agency" to administer this program in New Jersey.

Prerequisite to the distribution of federal funds in any state is the development of a plan, showing the requirements for additional hospitals and health centers throughout the state. The Department of Institutions and Agencies, in cooperation with its Hospital Advisory Council, is now engaged in formulating such a plan for New Jersey.

On September 8, 1947, there appeared under the imprimatur of the Department, a volume of 114 pages, entitled *Hospital and Public Health Resources in New Jersey*, comprising a source book of the facts and figures upon which the state plan is to be based. Much of the material in this book was originally assembled by the New Jersey State Commission on Postwar Economic Welfare, supplemented by material provided by many hospital, health and medical organizations, including The Medical Society of New Jersey.

Dr. Emil Frankel, Research and Statistical Director of the Department of Institutions and Agencies, directed the survey staff, assisted by Mr. William H. MacDonald, Chief of the Bureau of Local Health Administration in the State Department of Health.

The book brings our chief institutional problems and health needs into a sharp and satisfying focus. A few gross statistics follow:

Measured against the criteria of "adequate facilities" as defined in the Federal Hospital Survey and Construction Act, our state:

(a) has 14,431 general hospital beds and needs 4,289 more for a total of 18,720

(b) has 4,659 beds in tuberculosis sanitoria or allocated to tuberculous patients in other institutions, against a desideratum of 4,640, a surplus of 19 beds

(c) has 13,782 beds for mental patients, but should have 7,018 more, to a needed total of 20,800

(d) has 5,545 beds for care and treatment of "chronic" patients against a minimum of 8,320 required—a deficit of 2,775 beds

(e) should have 135 health centers.

When these over-all figures are broken down according to counties, and measured against the U.S.P.H.S. bed ratio standards we gain a more precise idea of our requirements. Thus, Ocean County a predominantly rural area whose recommended ratio would be 2.5 beds per 1000 population, is found to have a ratio of 5.25, rivalling Hudson's 5.57, the most amply supplied county in the State. On the other hand, Bergen County, which is predominantly urban, has a ratio of only 1.61 against a desirable ratio of 4.5.

Annual admissions to general hospitals in New Jersey have increased from 181,500 in 1933 to 278,645 in 1946, while the average patient day's stay in hospital has gone down 2 full days (from 13.7 to 11.7).

The average occupancy of all general hospitals in New Jersey in 1946 was 75.5 per cent (representing a rise from 64.9 in 1933). The recent upward trend (69.5 in 1944, 73.4 in 1945, 75.5 in 1946) will seriously strain our resources if it continues without being compensated by hospital expansion.

The number of out-patient visits declined sharply from 1938 to 1945. The cycle has started to reverse itself and in 1946 and 1947, the number increased.

From 1934 to 1940 the cost of operating New Jersey's general hospitals increased from $15,001,095 to $19,627,195; in the next six years, this rose to $40,566,275 an increase of more than 100 per cent. In the same period the daily per capita adult cost of general hospital care sky-rocketted from $5.95 in 1940 to $11.71 in the last quarter of 1946.

The overcrowding of state mental hospitals is alarming. Greystone Park shows a 34.2 per cent overload; Marlboro, 54.6 per cent, and Trenton State Hospital an overload of 8.7 per cent. The incidence of hospitalization for mental illness among the aged is increasing more rapidly than the ratio of aged people to the entire population.

On the other hand, New Jersey is well ahead of most states in the provision of out-patient mental clinics. The National Mental Hygiene program calls for one such clinic for each 100,000 of the general population. On this basis, our state should have 41 mental hygiene clinics. The report lists a total of seventy, of which 41 are operated by the state, and 29 by counties or municipalities.

There is wide variation among the several counties in the proportion of physicians to population. The most abundantly supplied area in this respect is Essex County (622 people per physician), followed by Cape May (689), Atlantic (738), Passaic (742) and Union (764). The most sparsely populated areas from a medical standpoint are Salem County (1281 people per doctor), Burlington (1198), Gloucester (1165), and Middlesex (1075).

There is a general parallel between the proportions of general hospital beds and of doctors to population in the counties.

James E. Bryan, Executive Officer.
The Medical Society of New Jersey.

NUTRITION IN EVERYDAY PRACTICE

S. William Kalb, M.D., Newark, N. J.
Chairman Nutrition Committee

1. *A patient cannot take whole protein. What substitute can he use to maintain nitrogen balance?*

   Protein hydrolysate (amigen) by mouth is just as effective as whole protein for this purpose.

2. *Is ice cream permissible in ulcer patients?*

   Chilled foods increase the severity of the ulcer syndrome. The volume of the acid is greater and the degree of total and free acidity is increased. Lowered temperatures in the stomach disturb the neutralizing mechanism of the gastric and duodenal secretion and is similar to that of histamine in its action on the gastric mucosa.

3. *Are vitamins of benefit in the treatment of eczema?*

   None are specific. However, unsaturated fatty acids may be important for the maintenance of normal skin. Lard or vegetable oils which are rich in unsaturated fatty acids may be added to the diets of patients with eczema.

4. *Do adolescent children require the same amount of ascorbic acid as is necessary for children or for adults?*

They require more ascorbic acid per kilogram of body weight to maintain tissue saturation than younger children or adults.

5. *Is lemon juice harmful to the teeth?*

Yes, if taken daily as some people do. It tends to destroy the enamel around the margins of the teeth and causes a projection of the fillings above the surface of the teeth.

6. *Are protein hydrolysates of any more value in the treatment of peptic ulcers than other commonly used methods?*

No. Rest in bed plus frequent feedings of milk, cream, and antacids usually relieve the symptoms.

7. *Will patients who take thiamine during their pregnancies have an easier labor?*

No. See the report, however, from the Leningrad Central Institute of Gynecology and Obstetrics. The report states that if thiamine is used when labor first begins an effective analgesia results. Intramuscular injection of thiamine 60 milligrams, plus 40 milligrams if the pain reappears. The analgesia appears within ten to fifteen minutes.

YOUR DIRECTORY INFORMATION CARD

Preparations are now being made to publish the new edition of the American Medical *Directory*. The last edition of the *Directory* was issued in 1942. During November, a directory card will be mailed to every physician in New Jersey, requesting information to be used in compiling the new *Directory*. Please fill out the card, return it promptly even if no change has occurred in any of the points on which information is requested. Data on the right half of the card will be used exclusively for statistical purposes. Even if you have sent in similar information recently, mail the card promptly to insure the accurate listing of your name and address. There is no charge for publishing the data nor are physicians obligated in any way.

The *Directory* is one of the prime contributions of the American Medical Association to the work of the doctors of the United States. In it, as in no other directory, one may find dependable data concerning physicians, hospitals and medical organizations. It provides full information on medical schools, specialization, memberships in special medical societies, tabulation of medical journals and libraries, and, indeed, on every important fact concerning the medical profession in which anyone might possibly be interested.

If you fail to receive one of these directory information cards by December 1, write at once to the following address requesting a duplicate card:

DIRECTORY DEPARTMENT (A.M.A.)
535 North Dearborn Street
Chicago 10, Illinois

PSYCHIATRIC LECTURES AT LYONS

All physicians are invited to attend and participate in the following series of psychiatric lectures to be delivered at the Veterans Hospital, Lyons, New Jersey, on Saturdays at 10 a. m.

November 15 and November 22—Margaret Mead on *Personality Deviations in Other Cultures.*

November 29 and December 6 — Carroll Pratt on *The Background of Psychosomatic Research.*

December 13—A. A. Brill on *Freud and His Pupils.*

APPROVED NEUROPSYCHIATRIC RESIDENCIES NOW AVAILABLE

Openings are available for neuropsychiatric residency at the Veterans Administration Hospital, Lyons, New Jersey.

The program consists of one, two or three years' training with intensive graduate teaching in clinical neurology and psychiatry, psychopathology, clinical psychology, neuroanatomy, neurophysiology, neuropathology and neuro-roentgenology; also experience in female and child outpatient psychiatry.

The type of instruction, supervision and training is carried out in accordance with the requirements of the American Board of Psychiatry and Neurology.

The Residency has been approved by the Council on Medical Education and Hospitals, American Medical Association and by the American Board of Psychiatry and Neurology.

THE JAPANESE HEALTH MISSION

The temper and attitude of the present Congress toward "Socialized Medicine" is probably reflected in the action of the Harness Committee investigating government publicity and propaganda.

This Committee has for six weeks, been investigating the "Health Mission to Tokyo", a group of federal employees who departed for Tokyo on August 28, 1947.

Representative Harness (R. Indiana) in his report lists eight specific charges:

1. "That the health mission to Japan is composed entirely and exclusively of men long identified in the public record as advocates and proponents of socialized medicine not only in the United States but throughout the world.
2. "That the real purpose of this mission is to lay the ground work for a system of socialized medicine in Japan.
3. "That the scheme for such a mission originated in the Division of Research and Statistics in the Social Security Board in Washington and nowhere else. (This is our old friend Isadore Falk.)
4. "That the nominal request for the mission was engineered through the General Headquarters of the Supreme Commander in Tokyo by federal employees sent from Washington for that particular purpose.
5. "That General Douglas MacArthur does not favor—and does not approve—any plan to establish compulsory socialized medicine in Japan.
6. "That the dispatch of this mission to Tokyo for the purpose indicated in Mr. Wandel's letter to Mr. Falk under date of June 14, 1947, is a gross misuse of public funds.
7. "That the real purpose of the mission is not to assist Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of socialized medicine.
8. "That although the questions here involved are of a health and medical nature, the Surgeon General of the United States Army was not consulted in reference to the problem involved."

NORMAN M. SCOTT, M.D.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

Enrollment: In force on September 30, 1947—131,871 persons with 5,104 persons enrolled under contracts with future effective dates for total of 136,975 persons.

Recent Increases in Schedule of Benefits. Anesthesia; general, spinal intravenous from $10.00 to $12.50 except for tonsillectomies and vaginal deliveries. Herniorrhaphy; inguinal or femoral from $75.00 to $100.00, bilateral $125.00.

When a patient, not entitled to full service benefits in accordance with the Schedule of Benefits of the Plan, requests the services of a Participating Physician, the patient and physician should agree in advance on the amount of any additional payment to be made.

Do not contravene the contract provisions. To do so reflects against the integrity of the entire profession and of the voluntary medical plan movement.

NORMAN M. SCOTT, M.D.

OBITUARIES

DR. ARTHUR M. BARROWS

Dr. Arthur M. Barrows, one of Trenton's oldest practitioners, died on October 10 in Mercer Hospital after a short illness. Dr. Barrows was born in 1875, and was graduated from Jefferson Medical College in 1901. After interning at St. Francis Hospital he opened an office in Trenton in 1903. Dr. Barrows was a member of the Mercer County Medical Society and several local fraternal organizations.

DR. EDWARD E. TERRELL

Dr. Edward E. Terrell of Cranford died on October 2, 1947, in Muhlenberg Hospital after a short illness. Born in Texas in 1903, he was graduated in 1931 from the Chicago School of Medicine and served on the staff of Rockefeller Institute in New York before coming to Cranford in 1934. Dr. Terrell served as a captain in the Army Medical Corps in World War II. He spent thirty-five months as chief of medical service for the 248th General Hospital, Clark Field, Luzon, in the Philippines.

NEW JERSEY STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH NEWS FOR THE PHYSICIAN

WHOOPING COUGH MANUAL AVAILABLE

Fresh from the press is a new publication *The Control of Whooping Cough in New Jersey* published by the State Department of Health. Written specifically for the medical profession and health officials, the 32 page manual includes a section for the family physician. Copies are available at no cost from the N. J. State Dept. of Health, Trenton 7.

THE CONTROL OF RABIES

The basic consideration in the eradication of a preventable disease is the recognition and control of the disease in the natural hosts. Rabies is a transmissible viral disease perpetuated and spread by animals. Medical historians have long portrayed rabies as a disease of dog, cat, wolf, fox and other members of the canine family, whose primary weapon of defense is biting. Since the presence of virus in the saliva of rabid animals is presumed to be constant, nothing could be more unfortunate for non-immune animals and man than a penetration of bite wound inflicted through unprotected skin in close proximity to the central nervous system.

The average annual prevalence of rabies among animals in New Jersey from 1932 to 1940, inclusive, was 312.5. During this period, the reported cases ranged from a low of 105 in 1937 to a high of 678 in 1939. From 1941 to the present time, reported cases range from 308 to 42; during this time *eight persons died of rabies.* This is an exorbitant price paid by the citizens of New Jersey for tolerating the existence of a preventable disease among dogs and cats.

Although the incidence of rabies among human beings in the United States seldom exceeds fifty individuals annually, it must be acknowledged that this low mortality rate is favorably influenced by appropriate medical local treatment of the bite wound and the prompt administration of prophylactic vaccine. Many persons who have not sustained actual bites but who have become exposed to the virus-laden saliva—(in attempting to administer treatment to the dog)—are advised by their physician to submit to prophylactic treatment. Since rabies infection can take place through the nasopharyngeal mucosa and the conjunctiva, this is sound advice.

Rabies is distinctly cyclical in occurrence. Reservoirs of infection are known to exist in some sections of New Jersey and it is from these points that excessive outbreaks of the disease largely originate.

In the light of present knowledge, and in concurrence with the principles proposed for a National Rabies Control Program, the New Jersey State Department of Health is of the opinion that the challenge imposed by rabies among animals in this state can be met only by adding to current methods of rabies control the proper administration of vaccines demonstrated to contain an abundance of protective properties against this enemy of animals and man.

PERSONALITY AND SOCIAL ASPECTS OF DISABILITIES

An unusual scientific program of interest to all physicians concerned with emotional and social problems or with problems in rehabilitation generally, is scheduled for Friday evening, November 28, 1947, at the Academy of Medicine, 91 Lincoln Park, Newark. Essayist of the evening will be Dr. Luther E. Woodward, Field Consultant to the National Committee for Mental Hygiene. The meeting is under the auspices of the Clinical Society of the Veterans Administration of New Jersey. Meeting opens 8:30 p. m. Dr. Woodward's subject will be. "Personality Aspects of Disabilities".

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held on Friday evening, October 10, 1947, at the Traymore Hotel with Dr. Clarence B. Whims, president, presiding. The guest speaker of the evening was Dr. Lawrence I. Kaplan, of Bellevue Hospital, New York City. He is associated with the Cornell Neurological and Neurosurgical Service, and was formerly Chief of Neurological Service at the Finney General Hospital, Thomasville, Georgia. His subject was *Neurology and the General Practitioner.*

Dr. Kaplan stressed the close relationship between the general practitioner and neurology. Inasmuch as the general practitioner is the one who first sees these cases in their acute stages, he should be well acquainted with the subject.

The following principles were laid down as essential in the treatment of neurological diseases; self-reliance, prevention of self-pity, reduction of self-awareness, cultivation of outside interests, and a daily routine.

He spoke on the various types and treatment of epilepsy. In the treatment, such drugs as phenobarbital, dilantin, amytal, and tridione were given their due place. Parkinson's Disease was discussed along with the present day method of treatment. Dr. Kaplan's paper ended with a concise review of the hemiplegias.

A very lively discussion of Dr. Kaplan's paper followed. The president thanked the speaker on behalf of the members.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The October meeting of the *Burlington County Medical Society* was held on the ninth of the month at the Riverton Country Club. The president, Dr. Warren E. Rodman, called on Dr. LeFavor to introduce the speaker of the evening, Dr. Reuben L. Sharp. The topic Dr. Sharp discussed was *The Irritable Colon.* He began his talk by stressing the prevalence of funtional nervous diseases and psychoneurosis. The general practitioner must be able to evaluate emotional disturbances and differentiate these from organic diseases. The body cannot be cured unless the mind is put at ease in regard to the condition of the body. Medicine and various treatments may be used but should be only adjuncts to psychotherapy. After this introduction Dr. Sharp discussed the four main divisions of his talk; namely, simple spastic colon, mucous colonitis, nervous diarrhea and simple constipation. He discussed the symptoms and treatment of each of these conditions. He continued his talk by saying the above conditions must be differentiated from carcinoma of the intestines, intestinal obstruction, diverticulitis, appendicitis, renal and billary colic, pelvic inflammatory disease, gastritis, and tuberculous peritonitis. It was a very interesting talk and he gave definite examples of the treatment of each of his four main topics.

Dr. E. Winfield Betts of Medford was elected treasurer, following the resignation of Dr. E. Vernon Davis.

Due to the death of Dr. Gerald E. McDonnel, Dr. E. Warren Rodman, president-elect, became president. Dr. E. Vernon Davis was elected vice-president.

Dr. Norman K. Boudwin was appointed to the Post-Graduate Committee to take the place of Dr. Rodman.

The Welfare Committee has been in contact with the County Welfare Board and has made recommendations for changes in their present policy. These recommendations were discussed and will be presented to the County Welfare Board.

Dr. Thomas Summey gave his report on the Tumor Clinic at the Burlington County Hospital. He discussed what the Tumor Clinic had accomplished and the expenses which were incurred. He invited all the physicians in the County to attend and participate in its work.

At the September meeting Dr. Harold E. Longsdorf was requested to compose a memorial resolution to the late Dr. Gerald E. McDonnel of Mount Holly. This resolution, which was read to the County Society and adopted, follows:

> Whereas our Heavenly Father has removed from us our friend, co-worker and recent President of our Society—Gerald E. McDonnel—to whose vision, zeal and work this Burlington County Medical Association owes a lasting debt of gratitude, and
>
> Whereas by his untimely death on September 3, 1947, every member of our society feels that he has lost a personal friend as well as a wise councilor;
>
> Therefore, be is resolved that this Society in regular session express its sorrow and deep sense of loss in the death of Dr. Gerald E. McDonnel, and that a copy of this Resolution be sent to Dr. McDonnel's widow and family; published in the Mount Holly Herald, and spread upon the minutes of our organization.

CAMDEN COUNTY

Harold K. Eynon, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held at the Camden City Dispensary on October 7, 1947. The meeting was called to order by the president Dr. James S. Shipman at 9:00 p. m. The entire program was given over to reports from the following committees which had been functioning throughout the year:

June Outing ..... Dr. G. P. Meyer
Cancer Control ..... Dr. H. Wesley Jack
Maternal Welfare ..... Dr. Samuel Goldman
Public Health ..... Dr. Martin H. Collier
An. Meeting of State Society .. Dr. Martin H. Collier

Medical-Surgical Plan of N. J.....Dr. T. K. Lewis
Annual Meeting of A.M.A.....Dr. T. K. Lewis
Building Improvement.....Dr. R. S. Gamon

Dr. Jack gave an excellent report revealing the complete details of the work, administration and finances of the Camden County Chapter of the American Cancer Society and compared its activities with those of the preceding year. The Medical-Surgical Plan was reported on by Dr. T. K. Lewis, who stated that the plan is now well entrenched in North Jersey and that a drive is to be put on to develop the plan in this area. Dr. Lewis also reported on the Annual Meeting of the American Medical Association, giving in particular very elucidating information on the Rich report and the functions of the National Physicians Committee. Both of his reports were well received and provoked considerable discussion. In the absence of Dr. T. B. Lee a report of the Board of Trustees was held over to a future meeting. Dr. R. S. Gamon reporting for the building improvement committee stated the committee recommended that the present building be sold and that more suitable quarters be obtained for the Society. This suggestion was acted upon favorably by the Society and the Board of Trustees was requested to take the necessary action.

The applications for membership of five physicians were read and referred to the censors. DR. LAWRENCE W. F. RYAN, 922 Haddon Avenue, Collingswood, New Jersey, was elected to membership. The meeting adjourned at 11:00 p. m.

CUMBERLAND COUNTY

E. C. Greene, M.D., Reporter

DR. SIDNEY L. SIEGEL presided at the regular meeting of the *Cumberland County Medical Society*, held October 14, 1947, at the Hotel Cumberland in Bridgeton.

By transfer from Camden County Society, DR. SHERMAN GARRISON, JR., was elected to membership.

A letter from the State Commission for the Blind was read and discussed. The society voted to support the Mobile Eye Clinic, providing it was used only for indigent patients.

As Chairman of the Cancer Committee, DR. ANTHONY PINO reported that $3000 had been allotted to the county by the State Cancer Society to be distributed among the three communities. However, it was mandatory that each establish a clinic for the diagnosis and treatment of cancer in order to receive its allotment. Dr. Pino presented the proposed plan for administration, personnel and functioning of these clinics and was authorized to proceed with the plan.

Dr. A. B. Kump introduced the first speaker, MR. JAMES E. BRYAN, Executive Officer of the State Society, who complimented the New Jersey group, but stressed the importance of the county society as a functioning unit. Mr. Bryan regretted that the good works of the medical societies could not be more frequently presented to the public rather than only the issues which they wished to contest.

DR. CHESTER I. ULMER, Councilor of the Fifth District, gave pertinent and well-chosen recommendations. Dr. Ulmer pointed out the advantages of having more frequent meetings and more visiting among county societies.

The speaker of the scientific program, DR. HENRY A. COTTON, Chairman of the State Advisory Committee on Mental Hygiene, was introduced by Dr. Charles Cunningham. In his talk on *Nervous and Mental Illness*, Dr. Cotton presented the subject in such a practical manner that it was of particular value to the practicing physician.

Dr. Cotton expressed regret that psychiatry was treated so briefly in the medical school curriculum, so much time being given to actual psychopathic cases and so little time to psycho-neurosis with which the general practitioner had to deal. He felt that so many psycho-somatic problems could more effectively be handled by the family physician if he were interested in practical psycho-therapy. By way of illustration, the speaker gave detailed histories of a few interesting cases and in discussing them suggested many points of practical value in psycho-therapy.

After informal questions and discussion, the meeting adjourned for dinner.

ESSEX COUNTY

Asher Yaguda, M.D., Reporter

The *Essex County Medical Society* Health Week opened to the public at 1 p. m., Monday, October 6, 1947. Publicity had been previously arranged and included newspaper items, radio talks and letter invitations to lay organizations throughout the county who were interested in various health problems. Publicity on Health Week continued during the entire period of Health Week with daily articles in the Newark Evening News, photographs of exhibits and advance publicity for speakers.

Twenty health exhibits had been set up by the various advisory committees to the sub-committee on Public Health covering subjects of interest to the lay public. These were well attended and drew much favorable comment. The exhibits especially liked by the public were those in which spectator participation was permitted, the so-called live exhibits. These included dark adaptation testing in the nutrition exhibit, hemoglobin determinations, testing of depth perception in the eye exhibit, testing of hearing by means of an audiometer and the demonstration of quick method of examination for cancer.

Motion pictures on health subjects were shown every afternoon and included Walt Disney cartoons and other films of interest to children. Motion pictures of interest to adults were shown at 7:45 p. m. each evening preceding the speaking program. Where possible, films related to the topic under discussion that evening were shown.

Each evening, lectures and discussion periods were held in the main auditorium on subjects of current interest to the lay public. The main topics discussed were heart disease, common communicable diseases, venereal diseases, care of the expectant mother and child, medical aspects of cerebral palsy and cancer.

The attendance for the week was in the neighborhood of 1500 people. The people attending the

meeting represented many lay organizations and as a result the story of Health Week will reach many times the actual number of people who attended. The Woman's Auxiliary clocked the attendance and also acted as hostesses and guides, thereby facilitating the smooth handling of the crowds.

GLOUCESTER COUNTY

L. K. Collins, M.D., Reporter

The annual social session and ladies' night of the *Gloucester County Medical Society* was held at the Woodbury Country Club, October 16, 1947, at 7 p. m. The President, Dr. Joseph Hughes, served as toastmaster, and handled the situation very capably.

The ninety-five members and guests present first enjoyed an excellent dinner while appropriate music was supplied by a trio. Dr. Hughes then introduced Mrs. Chester I. Ulmer, president of the Woman's Auxiliary to the Gloucester County Medical Society. Dr. Royal Schaaf, President of the State Medical Society, gave a short talk especially commending the Auxiliary. Short addresses followed by Gloucester County's representatives in Trenton, Senator Harold Hannold and Assemblyman Hugh Mehorter. It is pleasing to recall that our relations with these two men have always been of the best and that they have supported our views in Trenton to the best of their ability.

The principal speaker of the evening was Mr. John H. Davis of Reading, Pa. His topic was "Common Sense—Horse Sense—Nonsense" and a great deal of all three were mixed into his interesting presentation. Mr. Davis impressed upon the rapt listeners that in medicine especially, free enterprise was the keystone of democracy. Our present system of proved medical practice should be zealously preserved, and all attempts at foisting a scheme of socialized medicine on the unenlightened public, vigorously opposed. Also, at all cost, free enterprise in business must be preserved, lest we sink into the oblivious pit of totalitarianism and gradually disappear as individuals.

To conclude a delightful and thought-inspiring evening, dancing was enjoyed by the young and not so young.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society inaugurated its new season on October 7, 1947, when the first regular meeting of the official year was called to order by the president, Dr. Raymond S. Driscoll, at the Masonic Club in Jersey City.

Dr. Charles H. Finke, Jr., Jersey City, was elected to membership.

A symposium on *Disease of Liver and Bile Ducts* comprised the scientific session. It was arranged through the courtesy of Dr. R. Franklin Carter, Clinical Professor of Surgery, New York Post Graduate Medical School and Hospital. The speakers and their subjects were as follows. Dr. J. Wilfrid Forster, Assistant Physician, New York Post Graduate Medical School and Hospital—*Differential Diagnosis Between Organic Disease and Functional Disorders of the Gall Bladder;* Dr. J. Russell Twist, Assistant Clinical Professor of Medicine, New York Post Graduate Medical School and Hospital—*Recent Development in Diagnosis and Management of Liver Diseases;* Dr. R. Franklin Carter — *The Diagnosis and Surgical Management of the Successive Phases of Gall Bladder Disease.*

Discussants from the floor were Drs. Perkel, Macchia, Fifer and Alter. The discussion was terminated by Drs. Carter, Twist and Forster.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The first fall meeting of the *Monmouth County Medical Society* was held Wednesday evening, September 24, 1947, at the new auditorium in the Borden Memorial Pavilion, Monmouth Memorial Hospital, Long Branch.

Mr. Albert Teeter of the American Red Cross was the first speaker of the evening. Mr. Teeter presented an offer of the County Chapter of the Red Cross to undertake the management of the blood bank. This blood would be available for use in the hospital, sanatoriums, or private practice. The county medical society would authorize the men who would take the blood.

Dr. Nicholas Ransohoff presented the results of treatment of seventy cases of poliomyelitis in the Monmouth Memorial Hospital during the years of 1945-1946. Sixty-six of these cases have been followed completely. The treatment consisted of curare, physical therapy and psychotherapy. The results have been excellent.

Dr. Stanley Nichols was the first discussor. He was especially interested in the difficulty in the diagnoses. Drs. Hodas, Schmidt and Pisani also offered comments. Dr. Ransohoff closed the discussion with a review of the dangers of curare and three criteria of diagnoses of acute anterior poliomyelitis.

Dr. Charles Bailey, Director of Thoracic Surgery at the Hahnemann Medical College and Hospital, Philadelphia, Pa., was the guest speaker. His subject was *Cardiac Surgery.* The earliest operations for cardiac conditions were contrasted with those of today. Present cardiac surgery and future cardiac surgery were then outlined. Dr. Bailey considered the various conditions as acute and chronic tamponade of the heart, constructive periconditis and various congenital defects, etc., giving the diagnostic symptoms and signs and treatment. Dr. Bailey illustrated his paper by slides and moving pictures in kodachrome. This part of the program closed with questions by Dr. Nichols. The society enjoyed Dr. Bailey's instructive presentation, and they enjoyed his presence even more as he had interned in this hospital. Dr. F. J. Altschul spoke for the entire group when he thanked Dr. Bailey and when he spoke of Dr. Bailey's honesty, courage, skill and sense of humor.

The business meeting followed the scientific session immediately. The Society voted unanimously for the proposed amendment to the constitution.

Nominations for replacement of Dr. Carlos Pons on

the executive committee were presented. A vote was then taken and Dr. Byron Blaisdell was elected to replace Dr. Pons.

The following doctors were elected to full membership: DR. MILTON HAUT of Farmingdale, DR. KAHRS of Marlboro State Hospital. DR. EDWARD ARMAND MAZZI of Long Branch, DR. MADELINE BANTA of Red Bank, DR. ABRAHAM COLLIS of Long Branch, DR. ALVIN WEINSTEIN of Asbury Park and DR. KARBONITS of Asbury Park were elected to associated membership. DR. WILLIAM DONOVAN of Brielle was unanimously elected to honorary membership.

A motion was passed to accept the Red Cross offer to take over the stocking and running of the blood bank and to give the executive committee the power to proceed with the necessary arrangements.

SUSSEX COUNTY

Katherine E. Stewart, M.D., Reporter

The regular meeting of the *Sussex County Medical Society* was held at The Cochran House, Newton, on September 29, 1947, with 19 members attending.

DR. MARTIN I. KIRSCHNER, the president, introduced DR. JAMES F. NORTON, First Vice-president of The Medical Society of New Jersey, who spoke in general on the relationship of the State Society to the individual County Societies. Dr. Norton emphasized the fact that the feeling of any County Society that it was not getting "its money's worth" from the State Society was due wholly to the County Society's lack of representation and interest in the various state meetings and activities.

A lengthy discussion was held on the advisability of setting up an x-ray unit, to be donated by the State Department of Health to the Sussex County Tuberculosis League. It was decided to refer the matter to the Council of the Society for further consideration.

The plan for the establishment of a County blood bank by the American Red Cross was approved.

WARREN COUNTY

Joseph C. Humbert, M.D., Reporter

With the president, DR. WALTER A. BOQUIST in the chair, the *Warren County Medical Society* held its annual meeting at the Phillipsburg Elks Club on October 21, 1947.

DR. ROY COOPER was elected to membership, and the applications of DR. LEWIS E. GENNINGER and DR. ALEXANDER U. BERTLAND were considered and referred to the board of censors for approval.

A proposed amendment to the by-laws which would make the society meetings bimonthly was discussed at some length, and tabled, for action at the next meeting.

Members of the standing committees, as well as several committees to work with the Woman's Auxiliary for the promotion of the State Society's School Health Program, were appointed by the president.

The nominating committee recommended the following panel of officers, who were thereupon unanimously elected: *President,* DR. FRANK BARTOLINI; *Vice-president,* DR. JOSEPH C. HUMBERT; *Secretary,* DR. WILLIAM VARNEY; *Treasurer,* DR. A. C. ZUCK; *Censor,* DR. WALTER A. BOQUIST; *Reporter,* DR. JOSEPH C. HUMBERT; *Delegate,* DR. PAUL DRAKE.

The secretary stated that an irregular practitioner had been reported to the state society, and that an investigation was under way.

The meeting adjourned to the dining room, where dinner was served to members of the society and the Auxiliary.

NEW JERSEY ORTHOPAEDIC SOCIETY

R. R. Goldenberg, M.D., Reporter

The second annual meeting of the New Jersey Orthopaedic Society was held at the Hospital and Home for Crippled Children, Newark, on October 11, 1947.

The following scientific program was arranged by the Program Committee, Dr. Toufick Nicola, Chairman:

Morning Session: (1) Shelf Operation for Congenital Dislocation of the Hip—Harry Merliss, M.D., (by invitation); (2) Scoliosis—Rapid Method of Correction of Deformity—Preliminary to Spine Fusion—Vincent Scudese, M.D. (by invitation); (3) Basile Operation for Flat Feet—H. Kunz, M.D. (by invitation).

Afternoon Session: (4) Amputations in Europe—Henry H. Kessler, M.D.; (5) Saucerization and Skin Grafting for Chronic Osteomyelitis—J. J. Flanagan, M.D.; (6) Bone Tumors in Children—E. Seifert, M.D. (by invitation); (7) Operative Results of Bone Cysts—Henry D'Vincentis, M.D. (by invitation); (8) Osteoid-Osteoma — R. R. Goldenberg, M.D.

Thyroid Gland Essay Contest

The Van Meter prize of $300 will be awarded to the best original work on problems related to the thyroid gland. Copies should be submitted in triplicate and should not exceed 3,000 words. Closing date is February 1, 1948. For further information write to Dr. T. C. Davison, Doctors Building, Atlanta 3, Ga.

American Board of Obstetrics and Gynecology

The American Board of Obstetrics and Gynecology announces that the next written examination for all candidates will be held in various cities on Friday afternoon, February 6, 1948. Applications should be addressed to Dr. Paul Titus, Highland Building, Pittsburg 6, Pa.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Lodovico Mancusi-Ungaro, President

As wives of physicians we have long been entrusted with the honor of their names, the care of their homes, and the upbringing of their children. Never before have we been asked as an organization to take the leadership in so big a project, and one which will do so much to obtain a more thorough approach to better health for our children.

As members of the Woman's Auxiliary to The Medical Society of New Jersey I call upon you to be worthy of this trust, to assume the leadership in the school health program of your county auxiliary, that through our united efforts we may serve this noble profession and assist in building a healthier future for the children of our state.

THE NATIONAL CONFERENCE ON LOCAL HEALTH UNITS

PRINCETON, NEW JERSEY—SEPTEMBER 9-10, 1947

Under the auspices of the American Public Health Association, a National Conference on Local Health Units was held at Princeton University on September 9 and 10. Sixty-five national citizen and health agencies sent representatives to this meeting. Dr. Harry S. Mustard, then president of the organization, announced "The purpose of the Conference is to extend local health units over the country."

A local health unit, as defined in a resume of the meeting by the American Public Health Association, must supply to persons living within a specific local area or district, adequate public health and sanitation facilities.

I'll admit that, long before the Conference was over, I was well sold on the idea of setting up additional local health units throughout the country. But then, none of us has any sales resistance against the idea of more complete medical coverage for all sections where needed. The agency is another thing to be considered.

Dr. Haven Emerson told us that one-third of the people living in the United States have no or inadequate public health services. He urged consideration of the ideal that local rather than federal government is the proper source of basic health services. He cited the following division of financial responsibility: 50 per cent by local tax, 25 per cent by state funds and 25 per cent federal aid; ideal per capita expenditure $1.00. Dr. Emerson said that units of not less than 50,000 people are urged, if necessary overlooking county lines and taking in sufficient territory to service this number of persons. The perfect health unit is set up with the following personnel: 1 full time medical health officer, 1 full time sanitary engineer, with assistant, 3 non-professional assistants (including clerical) and 10 Public Health Nurses—the perfect ratio of nurses being one to 5000 population.

There was much talk of the necessity for health education, so much talk, in fact, that objection to the phrase was heated. From Dr. Emerson, as the first speaker, down through two days of papers and discussion, the need to inform the people, especially in rural communities, was emphasized. Dr. Florence Sabin pointed out that the work being done on setting up local health units in Colorado is one of self-education and the resulting insistence on the part of the people that they be provided with adequate health service. I liked this paraphrase of Dr. Sabin's theme "Give the people the facts, they can be trusted to act on them."

All agreed, also, on the need for the citizens health council, with representation from all classes in the community with a planning council at the state level, approved by the governor.

Until well into the first afternoon of the Conference I was left with the impression that the practicing physician was the forgotten man of the meeting. This, with more than fifty per cent of those men present, medical health officers. Finally, Dr. T. Paul Haney, until recently health officer of two counties in Mississippi, came forth with emphasis on the fact that, not only should the health officer be a physician but it is imperative that he have the confidence of all of the physicians in his community. He told of the state board of health in Mississippi, which gets its personnel in this way: the Mississippi Medical Society presents fourteen names of its members to the governor —two from each county. From this list the

governor appoints seven men to the state health board, and one man as state health officer, creating an entirely professional medical health board. There immediately came cries of "Monopoly, medical monopoly" with objections from the Negro physician who does not have the right of membership in that state society, and the discussion ceased only when time ran out.

New Jersey was singled out for attention as a state in which lay health officers have worked well.

The question of federal control of all health units was brought up in relation to the subsidy of the hospital construction program — this point was left hanging in air.

Altogether, it was an engrossing conference with a Utopian theme; how set-up 1200 local health units when many presently operating are sorely understaffed? How persuade medical students to complete their medical education, spend additional money for public health instruction and go to work for part of what they can earn in private practice? How recruit more thousands of nurses in the face of the present nursing emergency? How persuade technicians to work for less than half the salary obtainable in private institutions?

In spite of all obstacles, four national organizations vied for the privilege of establishing these local health units all over the country; they were The American Legion, The Parent Teachers' Association, the Kiwanis and the Federation of Women's Clubs.

It was my intention to close this report here and leave you with the picture of four non-medical organizations competing for leadership in a project which should have medical guidance. However, our president has asked me to bring in suggestions as to how the Woman's Auxiliary can take some helpful part in this program. I suggest that:

(1) The county councils which are now being formed as advisors in the School Health Program ultimately be expanded to include representation from all civic-minded groups. These expanded councils will then be in a position to stimulate public demand for adequate public health facilities.

(2) The Woman's Auxiliary enlist the aid of influential voluntary women's organizations of New Jersey in forming such councils.

(3) In consideration of the importance of education of the people regarding basic health service, the County Auxiliaries embrace item No. 2 of the Public Relations Committee Bulletin of September 1, 1947, which has been changed to read as follows: "Presentation of 'Rural Health Programs' with exhibits, films and speakers to the 4-H clubs for the children and to the local Grange chapter for the parents. Speakers for these programs are to be Auxiliary members trained for the purpose. They will present health education talks to be prepared and furnished by the Bureau of Health Education of the American Medical Association and which will have the full approval of the Advisory Board of The Medical Society of New Jersey."

MRS. ASHER YAGUDA.

EXECUTIVE BOARD MEETING

MRS. THOMAS H. MCGLADE, Press and Publicity

The Woman's Auxiliary to The Medical Society of New Jersey held its fall meeting of the Executive Board on Monday, October 13, 1947, at 315 W. State Street, Trenton, N. J. Mrs. Lodovico Mancusi-Ungaro, President, presided. Fifty-eight members were present.

Mr. James E. Bryan, new executive officer of the State Medical Society was introduced during the morning session. Mr. Bryan helped to clarify the plan of the Health Council to those attending the Public Relations discussion, preceding the regular meeting.

The reading of the reports of the county presidents and state chairmen comprised the morning business.

Miss Lula P. Dilworth, State Department of Public Instruction, Trenton, N. J., was the speaker of the afternoon. She delivered a most instructive and comprehensive talk on "The Role of the School Nurse in the Health of the School Children of New Jersey". An outline of the origin and duties of the school nurse in her health work, from one half century ago to the present day, was included. The role of the nurse is the Health Consultant in school and Liaison Officer between school and community.

COUNTY PROJECTS

Essex County

MRS. DANIEL E. KAVANAUGH, President

The Auxiliary of Essex County consisting of about 320 members has been requested by our County Society to work in very close alliance with them this year. We are to hold ourselves in readiness to assist them when called upon. Therefore we have prepared our program so that our meetings and topics are closely correlated with the program of the County Society.

We have been invited to attend the opening dinner meeting of the County Society. This indicates a recognition of the value of our organization to our County Society. We also have been invited to attend certain of their Committee meetings so that we will be cognizant of their plans and objectives.

The assistance of the Auxiliary proved to be invaluable during the extensive program of Health Week which was the opening activity of a long range program planned by the County Society to educate the lay citizenry in matters of public health.

We are also planning an all-day program on Public Relations in April 1948. The topic for this day has not yet been announced.

Prior to each meeting we mail a News Letter to every member in order that each one may be kept abreast of the progress of the Auxiliary activities to date. This is particularly helpful to those members who have missed meetings. If any other County President is interested in a similar project, please let me know and we will be more than glad to send her a copy.

OBITUARY

MRS. CHARLES F. ADAMS

Mrs. May Robeson Adams, widow of Dr. Charles A. Adams, died on October 9, at the home of her son in Trenton. Mrs. Adams was a charter member of the Woman's Auxiliary to the Mercer County Medical Society and served as president of the State Auxiliary in 1932-1933. She was an active member of her county auxiliary and initiated the Nurse Scholarship Fund when she became chairman of the Nurse Scholarship Award Committee in 1938.

Mrs. Adams was a past president of The Contemporary Club, the American Legion Auxiliary and the International Institute. She helped organize the Carolyn Stokes Day Nursery, was a charter member of the Y.W.C.A., and was a member of the board of managers of the Ladies Aid Auxiliary of Mercer County. During the war she served in the OPA.

Mrs. Adams is survived by two sons, Charles Franklin Adams, Jr., of Trenton, and Edgar Mercer Adams of California, and two grandchildren, Charles Franklin Adams, III, and Barbara Jeanne Adams, both of Trenton.

COUNTY AUXILIARY REPORT

Atlantic County

Mrs. Matthew Molitch,
Chairman, Press and Publicity

Mrs. Edward H. Dyer, newly elected president of *The Woman's Auxiliary to the Medical Society of Atlantic County,* entertained her executive board at a luncheon in Longport, on August 13. Following the luncheon, plans were formulated for the coming year.

Mrs. Robert Bradley, chairman of arrangements, presented a tentative program. At the opening session, which will be held on October 10, the society expects to be honored by the presence of the New Jersey State President and President-elect, and Mrs. Dyer will be in charge of the meeting. Scheduled for November 14, is a book review with Mrs. William O. Roop as chairman. The meeting on December 12, will be a Christmas party at which Mrs. Clarence Whims will be chairman. Mrs. Ruffin Stamps, chairman of public relations, will be in charge of the meeting on January 9, 1948, at which time a Reciprocity Tea with the Woman's Club of Atlantic City will be held. A musicale at the home of Mrs. James Mason will take place on February 13, 1948. Mrs. Daniel Reyner, chairman of legislation, will lead the meeting of March 12, 1948, and on April 9, Mrs. William Hersohn will provide a lecturer on a novel topic. The installation luncheon for the meeting of May 14, 1948, will be under the capable supervision of Mrs. Anthony Merendino.

Mrs. Irving Shavelson, chairman of Ways and Means, announced that a Sweepstakes Dance will be held to augment the funds in the Student Nurse's Loan Project.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX **November, 1947** **No. 11**

THE MOUNTING TOLL of heart diseases and cancer, which are primarily disorders of middle and late life, tends to foster too much complacency over the continuing reduction in the death rate due to tuberculosis. It is well to be reminded that the death figures tell but one side of the story. To look behind mortality statistics and to consider their real meaning in terms of lives saved or ended prematurely is a salutary corrective to unwarranted optimism regarding tuberculosis.

TUBERCULOSIS DEATH RATE FAILS TO TELL THE ENTIRE STORY

The best available single index as to the status of tuberculosis control is and always has been the mortality rate from this disease. The success of the tuberculosis program is best measured by the steady decline in the death rate during the past several decades. It is an impressive fact that tuberculosis mortality in the country as a whole has declined 53 per cent between 1924 and 1944.

The drop in tuberculosis mortality varies widely in the sex and color groups. The greatest decline in the past 20 years, for example, has been registered in the death rate for white women among whom the drop was 67 per cent; among non-white men, on the other hand, tuberculosis mortality declined but 42 per cent during the same period. (According to the last Federal Census, 99.4 per cent of all non-whites in the United States were Negroes; hence the two groups are almost identical.)

Table 1 shows for each sex and color group the tuberculosis death rates in the past two decades, as well as the percentage decline in mortality.

Sex and color	Tuberculosis death rate			Percentage decline in tuberculosis death rate	
	1944	1934	1924	1924-1944	1934-1944
All groups	41.3	56.7	87.9	53.0	27.2
White	33.7	46.2	74.9	55.0	27.1
Male	45.0	52.7	79.3	43.3	14.6
Female	23.3	39.6	70.4	66.9	41.2
Non-white	106.2	148.8	218.6	51.4	28.6
Male	122.7	156.9	215.0	42.1	21.8
Female	91.3	140.8	222.3	58.9	35.2

For no major cause of death has a mortality decline been recorded which campares favorably with the drop in the tuberculosis death rate. On the contrary, mortality from heart diseases, cancer, and certain other leading causes has increased rather steadily while that from tuberculosis has been dropping continuously.

Table 2 gives the 1944 death rates from these three major causes for each sex and color group.

Sex and color	Death rate per 100,000 population in 1944		
	Heart diseases	Cancer	Tuberculosis
All groups	315.4	129.1	41.3
White	310.1	128.8	33.7
Male	398.6	135.5	45.0
Female	254.2	133.3	23.3
Non-white	239.0	81.9	106.2
Male	274.3	75.6	122.7
Female	220.6	92.2	91.3

These death rates, though admittedly correct, tend to be misleading as to the relative importance of these three diseases. More of those who die of heart diseases and of cancer are elderly than is the case with those who die of tuberculosis. Moreover, tuberculosis is not only communicable but is preventable to an extent greater than either heart diseases or cancer.

A computation made to show the potential loss

in years of life resulting from deaths from heart diseases, cancer, and tuberculosis in 1944 demonstrates vividly the seriousness of the disease which too often leads to prolonged illness and death in youth or middle age. This computation is based on the expectation of life at birth, as published by the Metropolitan Life Insurance Company in its Statistical Bulletin for May, 1946.

Separate analyses have been made for white and non-white men and women since these groups vary widely not only as to their expectation of life, but in the age distribution of deaths from certain causes.

The method used in this computation is simple indeed. For example, the average white woman may expect to live 69 years. If she dies at the age of 24 from tuberculosis, she lost 45 potential years of life, whereas if she dies at 62 of heart disease, she has lost but seven potential years.

In the aggregate 1,929,953 potential years of life were lost by all Americans who died of heart disease in 1944, compared with 1,287,245 potential years lost by those who died of cancer and 1,175,500 by those who died of tuberculosis in that year. In other words, because of the differences in the ages of those who died from these diseases, the potential loss in years of life occasioned by deaths from tuberculosis is within ten per cent of the loss caused by cancer, even though the tuberculosis death rate is but 32 per cent of the cancer death rate.

In spite of the fact that the mortality from heart diseases is seven and one-half times as high as that from tuberculosis, the potential years of life lost by those who died of heart disease in 1944 were less than twice as numerous as the years lost by those who died of tuberculosis in the same year.

For many years the steadily declining tuberculosis death rate has been emphasized as the most significant evaluation of tuberculosis control. Less importance has been attached to a secondary result, namely, that not only are those who die of tuberculosis fewer in number each year but the median age at death becomes somewhat higher. These two encouraging developments have led some persons to the erroneous conclusion that tuberculosis is no longer a serious problem in this country. Yet, in spite of the declining death rate and the advance in the median age at death from tuberculosis, deaths from tuberculosis occur at much younger ages even today than do deaths from heart diseases and cancer.

It is clear from these findings that tuberculosis still constitutes one of our most serious social problems because of the comparative youth of the patients and decedents. Since all cases of tuberculosis are preventable the disease also presents a more acute public health problem than do other major causes of death. Tuberculosis is unquestionably the most serious public health problem among non-white races; moreover the gravity of this disease among white men has never been given proper consideration.

Decline in Tuberculosis Death Rate Fails to Tell the Entire Story, Mary Dempsey, The American Review of Tuberculosis, August, 1947.

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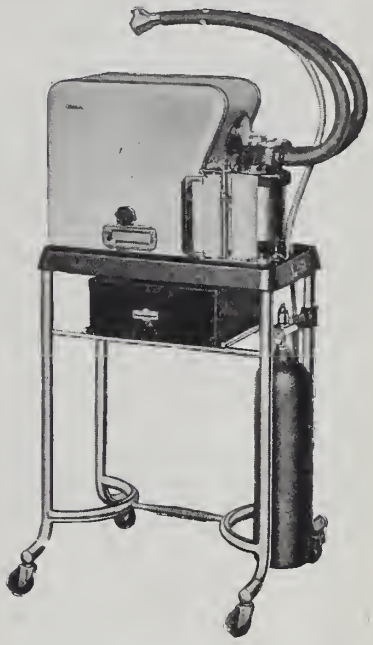
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[1]Human Fertility 10: 25 (Mar.) 1945.

[2]Warner, M. P.: J.A.M.A. 115: 279 (July 27) 1940.

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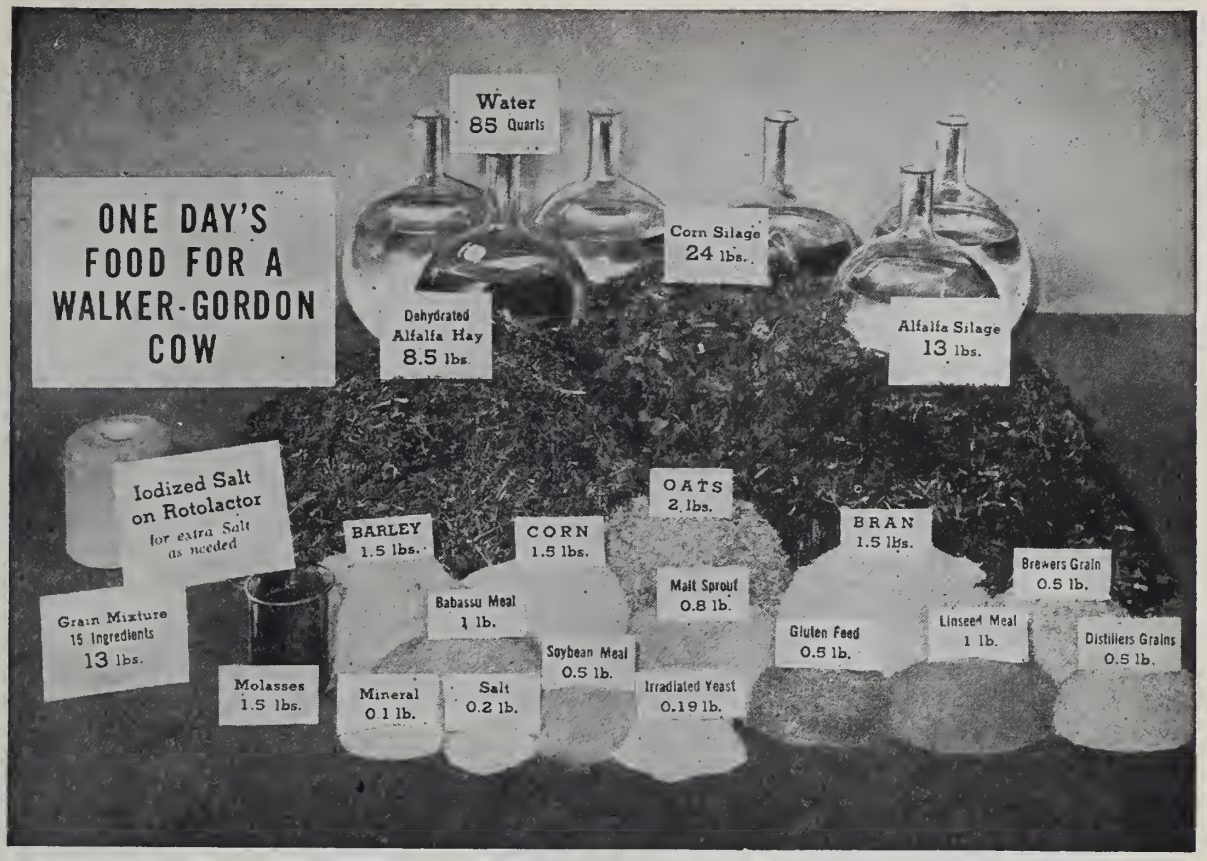
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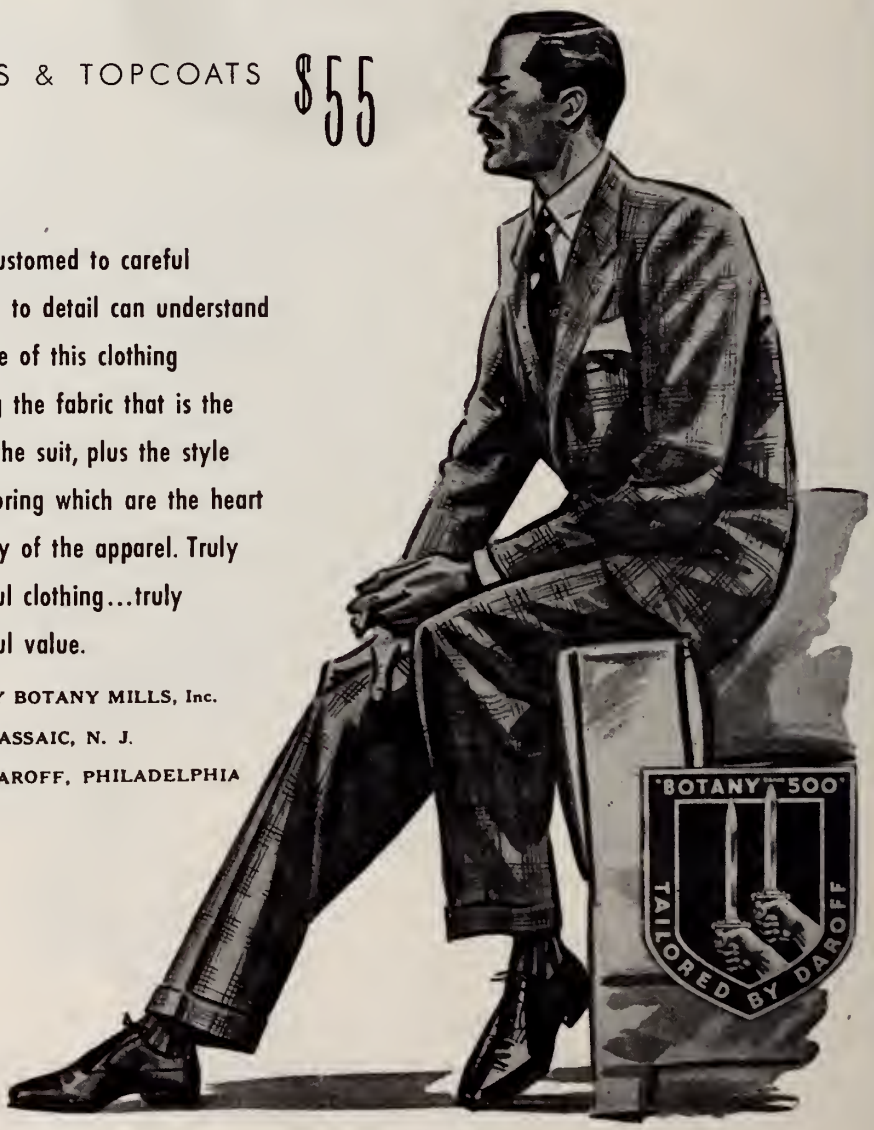
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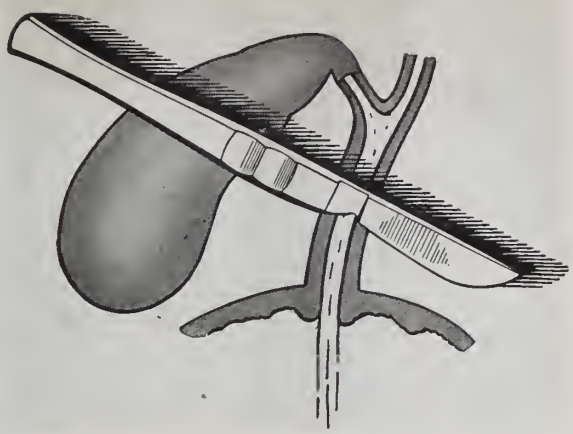
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*Goldthwait, J. E., Brown, L. Y., Swaim, L. T., and Kuhns, J. G., *Body Mechanics in Health and Disease*, 103-105, J. B. Lippincott Co., Philadelphia, 1937.

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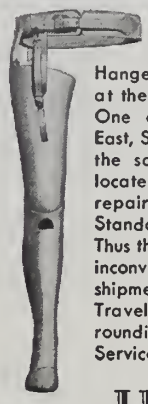


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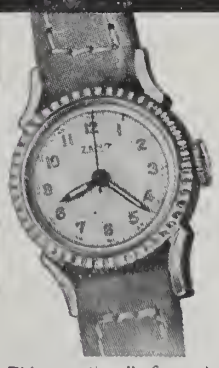
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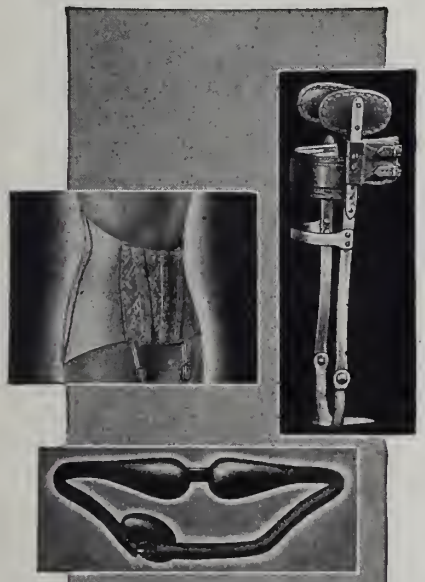
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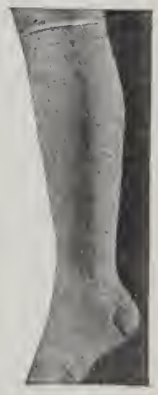
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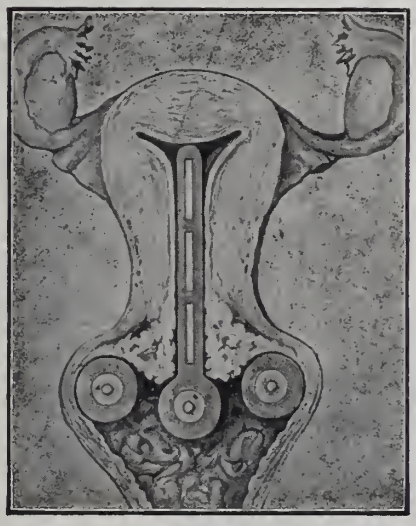
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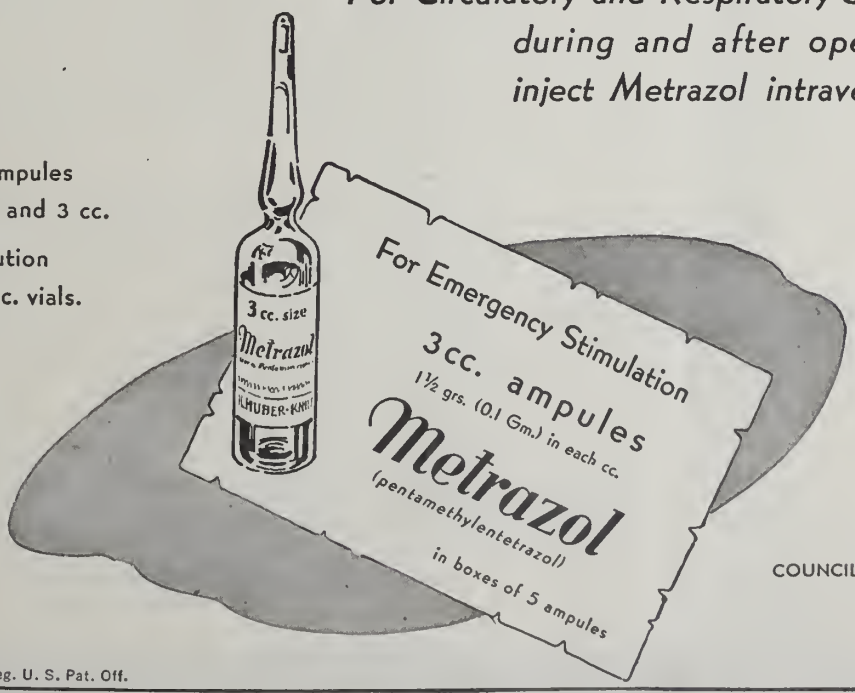
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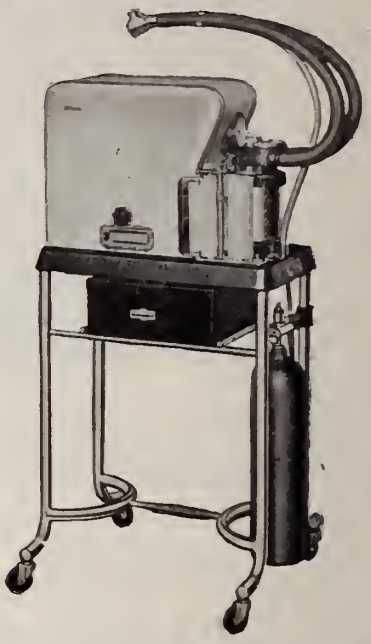
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In producing this new basal unit, we have endeavored to produce an instrument which incorporates all the desirable features of modern scientific metabolism equipment.

Our No. 186 Metabolor has many features not found in other units and is a product of many years' experience in manufacturing metabolism equipment. We invite you to check over the many advantages we offer and compare our instrument with other equipment in this field. Write for Catalog and Prices.

SPECIAL
Examining Paper, table
6 rolls — $9.95
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WE BUY AND SELL
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SPECIAL
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Fully Guaranteed
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humpty dumpty



The precarious dietary balance of many patients makes them particularly vulnerable to a nutritional 'fall' when subjected to some physiologic strain: febrile illness, hyperthyroidism, pregnancy, a period of unusual physical exertion, diarrhea, convalescence; pre-and postoperative stress, or perhaps mere curtailment in food intake.[1, 2]

Rely upon **APC** Council Accepted Vitamins to help the diet maintain adequate vitamin levels in such patients. Potency standardized by a multitude of exacting controls, easy to take, and low in cost, both physician and patient appreciate . .

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- Ascorbic Acid Tablets APC U.S.P., 25 mg., 50 mg., 100 mg.
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- Percomorph Liver Oil (50%) with Viosterol CODANOL Brand, Dosage Dropper Bottles, 10 cc. and 50 cc.

had a great fall



SAMPLE OF ANY OF THE ABOVE AVAILABLE ON REQUEST

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MANUFACTURING CHEMISTS • NEW YORK 18, N. Y.

1. Bull. N. Y. Acad. Med. 18:497, 1942. 2. J.A.M.A. 132:558, 1946.

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Those who develop dermatitis from the use of soap or whose existing skin disorder is aggravated by soap, need a soapless, hypo-allergenic, well tolerated and efficient cleanser.

pHisoderm, a modern detergent emulsion which contains no fatty acids, alkali, color or perfume, effectively cleanses without irritation.

pHisoderm is well tolerated by the skin and scalp of infants and children as well as adults.

pHisoderm makes an abundant lather in hard or soft water, and is more surface active and speedier than soap.



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Write for detailed literature and samples

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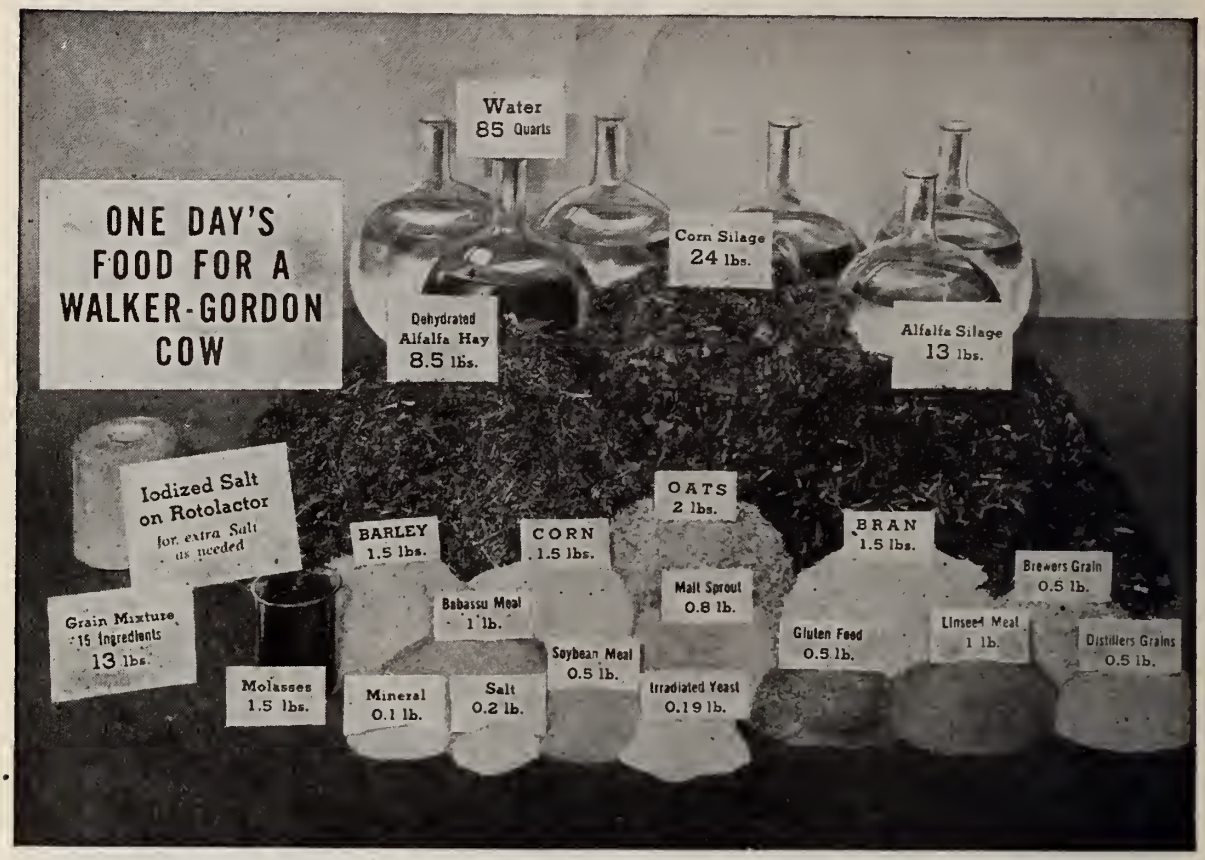
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The businesses formerly conducted by Winthrop Chemical Company, Inc. and Frederick Stearns & Company are now owned by Winthrop-Stearns Inc.



How many cows get a scientific ration like this?

THIS SCIENTIFIC daily ration was developed after years of study by the Walker-Gordon Laboratories.

It's remarkably rich in vitamins and health-giving minerals . . . And that's one big reason why Walker-Gordon cows produce a milk far superior to the type you get from cows that are fed in the ordinary, unscientific way.

Take Vitamin A, for example. The alfalfa fed a Walker-Gordon cow is not ordinary alfalfa, but a special dehydrated kind containing more Vitamin A. As a result, her milk contains 60% more Vitamin A than many ordinary milks.

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.Then, too, Walker-Gordon Certified is delivered fresher than ordinary milk. This, plus the cows' wonderfully balanced diet, makes its Vitamin C content higher . . . and gives it a much finer, richer taste.

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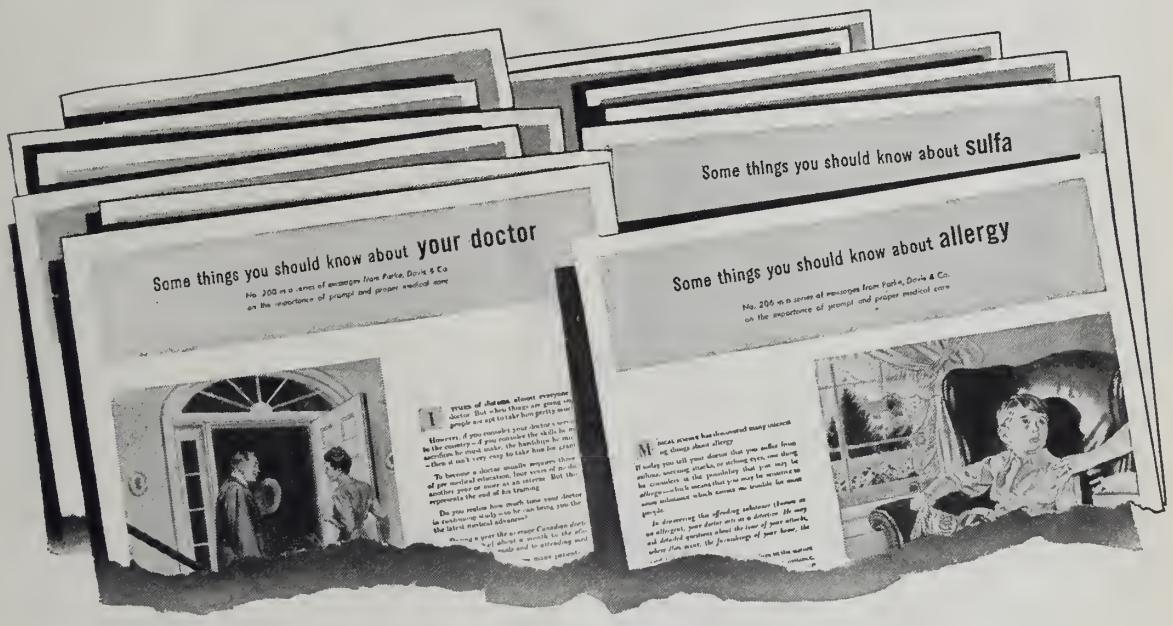
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For free illustrated booklet, write to Walker-Gordon. Plainsboro, N. J

"See Your Doctor"

A Continuing educational campaign

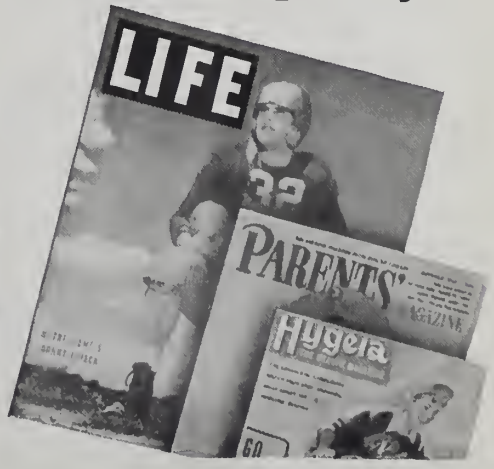


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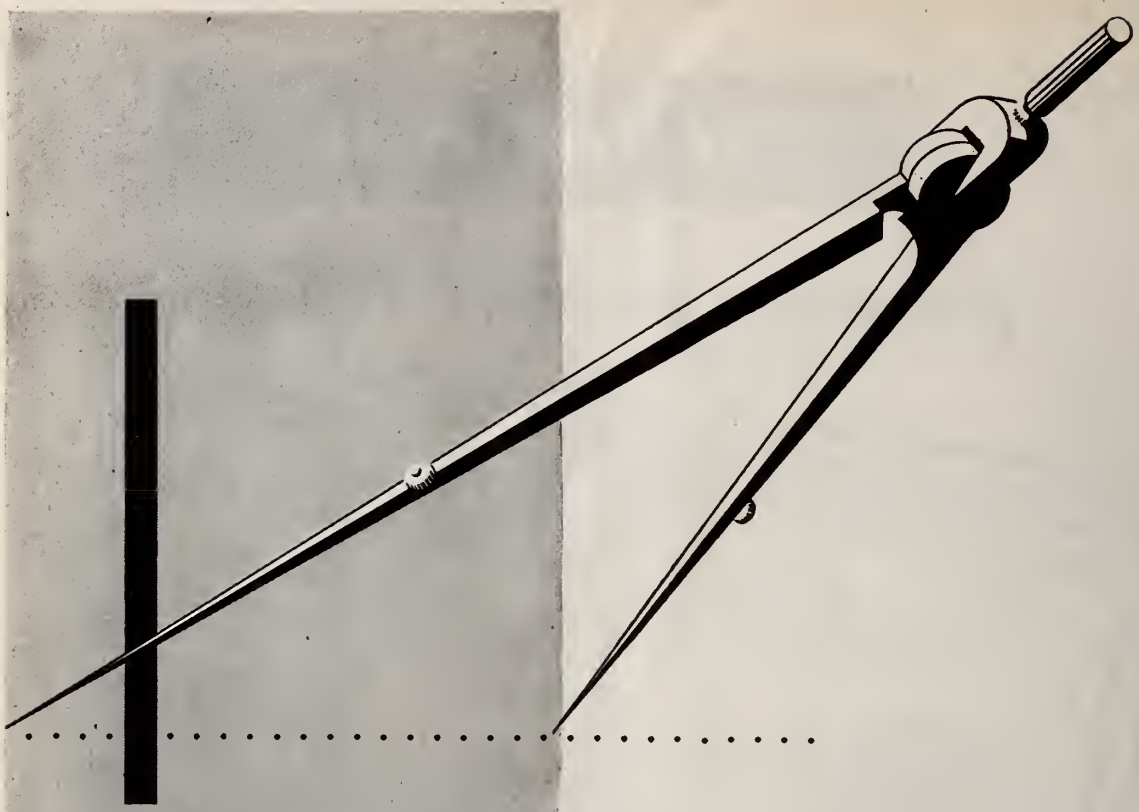
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Alert people. The readers of LIFE and other important national magazines. People of action and influence in every community.



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For a wider margin of safety

Syntropan* 'Roche' — non-narcotic antispasmodic — relaxes smooth muscle spasm by direct action on the muscle cell and by exerting an inhibiting influence on the parasympathetic terminations in smooth musculature.

Unlike atropine or belladonna, when Syntropan 'Roche' is given in therapeutic doses, there is very little likelihood of mouth dryness, mydriasis or tachycardia. The dual action plus the wide margin of safety make Syntropan a most effective and desirable antispasmodic. HOFFMANN-LA ROCHE INC · NUTLEY 10 · N. J.

* Reg. U. S. Pat. Off. Syntropan 'Roche' is the phosphate of *d, l*-tropic acid ester of 3-diethylamino-2, 2-dimethyl-1-propanol.

SYNTROPAN 'ROCHE'

NON-NARCOTIC ANTISPASMODIC

"What are the MAGIC WORDS?"

No magic words, no magic wand can improve a cigarette. *Something more tangible is needed.*

PHILIP MORRIS superiority is due to a different method of manufacture, which produces a cigarette *proved* definitely less irritating to the smoker's nose and throat.*

Perhaps you prefer to make your *own* test. Many doctors do. There is no better way to prove to your own satisfaction the superiority of PHILIP MORRIS.

* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



PHILIP MORRIS

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"Safeguard Their Vision"

"BE SURE THAT WHEN YOU INSTRUCT YOUR PATIENT TO HAVE HIS EYES EXAMINED— THAT HE IS DIRECTED TO YOUR COLLEAGUE THE OPHTHALMOLOGIST — ONE WHO IS NOT INTERESTED IN THE SALE OF EYE GLASSES."

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a modern

infant food



FORMULAC Infant Food is a concentrated milk in liquid form, fortified with all vitamins known to be necessary to adequate infant nutrition. No supplementary vitamin administration is required.

By incorporating the vitamins into the milk itself, the risk of human error or oversight is reduced. FORMULAC contains sufficient B complex, Vitamin C in stabilized form, Vitamin D (800 U.S.P. units), copper, manganese and easily assimilated ferric lactate—rendering it a flexible formula basis both for normal and difficult feeding cases. The only carbohydrate in FORMULAC is the natural lactose found in cow's milk. *No carbohydrate has been added.*

FORMULAC, a product of National Dairy research, has been tested clinically, and proved satisfactory. It is promoted to the medical profession alone. FORMULAC is on sale at grocery and drug stores nationally.

• For further information about FORMULAC, and for professional samples, mail a card to National Dairy Products Company, Inc., 230 Park Avenue, New York 17, N. Y.



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MODERN TESTED DIAPER SUPPLY

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FOR CUSTOMERS' *EXCLUSIVE* USE

Washed separately, dried separately, packed separately.

- The container furnished for used diapers while in the home sprinkles contents with an efficient antiseptic solution.
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"Ain't that something? *My* muscles aren't flabby fat—'cause (thanks to you) I have plenty of protein in my *Biolac*."

In fact, BIOLAC supplies among other essential nutrients the valuable proteins of milk (and thus the essential amino acids for sound structural development)—at a significantly higher level than human milk. By homogenization and heat treatment, curd size and tension are reduced for digestibility, and proteins are rendered desirably hypoallergenic. • BIOLAC is a *complete food* (when vitamin C is added). Its fat content is adjusted to a readily assimilable level, and its added lactose contributes to the formation of natural, soft stools. Mothers appreciate BIOLAC because of its safety and simplicity.

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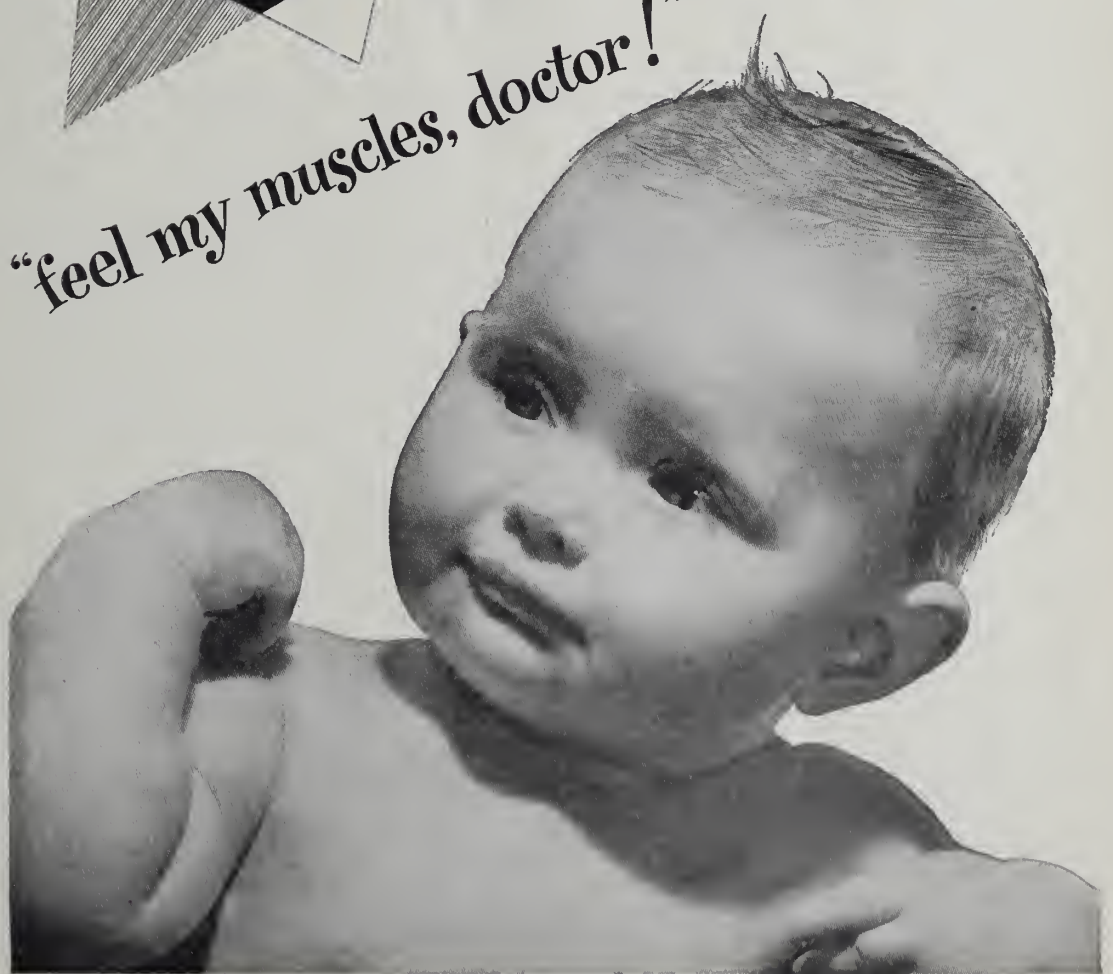


Biolac

"Baby Talk for a Good Square Meal"

Biolac is a liquid modified milk, prepared from whole and skim milks, with added lactose and fortified with vitamin B_1, concentrate of vitamins A and D from cod liver oil, and iron citrate. Evaporated, homogenized and sterilized. Vitamin C supplementation only is necessary. Available in 13 fl. oz. tins at all drug stores.

"feel my muscles, doctor!"



A richer life...



...for your petit mal patients

Immediate and substantial improvement in the great majority of cases—that is the encouraging prospect offered by Tridione to thousands of children suffering from *petit mal*. Tridione has achieved an outstanding clinical record in this field. In one study, for example, Tridione was given to 166 patients suffering from *petit mal* (pyknoepilepsy), myoclonic jerks or akinetic seizures.[1] This group had received only mediocre benefits from the use of other medicaments. With Tridione *83% were definitely improved.* Thirty-one percent became free of seizures; 32% had less than one-fourth of the previous number; 20% improved to a lesser extent; 13% were unchanged; and only 4% became worse. Furthermore, in some cases the seizures *did not return* when Tridione was withdrawn. • Clinical investigations have also shown that Tridione is beneficial in certain psychomotor cases when combined with other antiepileptic therapy.[2] You may obtain Tridione in 0.3-Gm. capsules and in pleasant-tasting aqueous solution containing 0.15 Gm. per fluidrachm. Wish literature? Just drop a line to ABBOTT LABORATORIES, North Chicago, Ill.

Tridione®

(Trimethadione, Abbott)

1. Lennox, W. G. (1947), Tridione in the Treatment of Epilepsy, J. Amer. Med. Assn., 134:138, May 10. 2. DeJong, R. N. (1946), Further Observations on the Use of Tridione in the Control of Psychomotor Attacks, Am. J. Psychiat., 103:162, Sept.



PRIVINE

(brand of naphazoline) Trade Mark Reg. U. S. Pat. Off.

PROMPT, LONG-LASTING VASOCONSTRICTION

Privine hydrochloride promptly shrinks congested nasal mucous membranes, inducing vasoconstriction which lasts for several hours. Only three drops in each nostril t.i.d. are usually sufficient. Other important qualities which have gained for Privine its prominent position in the field of nasal therapy are: pH of 6.2 to 6.3; aqueous, isotonic solution; non-injurious to nasal mucous membrane; minimal side reactions. Furnished as solution in dilutions of 0.05 and 0.1 per cent, and as jelly in 0.05 per cent concentration.

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SUMMIT, NEW JERSEY

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PYRIBENZAMINE

(brand of tripelennamine) Trade Mark Reg. U. S. Pat. Off.

NOW READILY AVAILABLE

Whenever antihistaminics



are indicated

Atopic dermatitis — flexural eczema. Pyribenzamine relieves itching in acute and chronic eczema in a substantial number of cases.

In its comparatively low frequency of side reactions, permitting larger doses where needed, Pyribenzamine offers important therapeutic advantages whenever antihistaminic medication is indicated. This new product of Ciba research is characterized by its capacity to counteract many of the effects of histamine. It prevents and controls certain allergic manifestations believed to be caused wholly or in part by release of histamine. Its action is palliative, not curative.

In the suggested list of indications below, Pyribenzamine has been used advantageously by many clinical investigators.

Chronic Urticaria • Acute Urticaria • Dermographism • Angioneurotic Edema
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Detailed information and samples of Pyribenzomine con be obtoined by writing the Professionol Service Division

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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The Cardiologist is assured of

Dependability in Digitalis Administration

Being the powdered leaves made into
physiologically tested pills,
all that Digitalis can do, these pills will do.

Trial package and literature sent to physicians on request.

DAVIES, ROSE & COMPANY, Limited
Manufacturing Chemists, Boston 18, Massachusetts

D14



FOR BETTER NUTRITIONAL HEALTH IN THE AGED

Impaired strength and poor general health in the aged, which have so erroneously become associated with senility, are in reality often due to no more than a state of subnutrition. Food dislikes, personal idiosyncrasies, masticatory difficulties, and digestive abnormalities are the usual contributing factors. The use of an easily digested, nutritious food supplement can do much in preventing these nutritional deficiencies, and in giving new strength and vigor to patients well advanced in years.

The delicious food drink made by mixing Ovaltine with milk is advantageously employed in augmenting the nutrient intake of the aged. This well rounded dietary supplement imposes no digestive burdens, and provides in generous amounts the very nutrients needed. Because of its low curd tension, it leaves the stomach quickly, and is easily digested. The table indicates its rational nutritional composition. Two or three glassfuls daily bring to full nutritional acceptability even a fair diet.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.



Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

NOW.... A Truly Modern Home Cleaning Appliance



LEADING home economists have called Rexair, "The greatest advance in home cleaning methods in more than thirty years."

There is a reason for this enthusiasm. That reason is Rexair's entirely new cleaning principle.

To begin with, Rexair uses neither a bag nor a filter. Bags and filters depend for their operation on *porousness*. They must be porous to let the air escape; and when air escapes, small particles of dust escape with it. You take dust from the floor and actually blow it into the air you breathe.

Bags and filters also clog up, and then cleaning efficiency drops.

Rexair completely does away with bags, filters, screens, or anything else that depends on porousness for its operation. Instead Rexair—*and only Rexair*—uses a bath of pure water to catch and hold dust and dirt.

Wet dust cannot fly. A water bath cannot clog up. Learn more about Rexair today!



SEND FOR THIS FREE BOOK

The complete story of Rexair, told in colorful pictures and text. Shows how Rexair performs all home cleaning tasks and gives vitalizing freshness to the air you breathe.

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TRADEMARK REG. U.S. PAT. OFF.

- Immobilizes sperm in the fastest time recognized under the Brown and Gamble measurement technique;
- Does not liquefy at body temperature nor separate on standing . . . not unduly lubricating;
- Maintains an occlusive film over the cervix uteri for as long as 10 hours after coitus as confirmed by direct-color photography;
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For the optimum protection which can be furnished by a vaginal jelly—"RAMSES"* Vaginal Jelly can be specified with the confidence that no better product is available. Active ingredients: Dodecaethyleneglycol Monolaurate 5%; Boric Acid 1%; Alcohol 5%.

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quality first since 1883

*The word "RAMSES" is a registered trademark of Julius Schmid, Inc.





Swift's Strained Meats

specially prepared— fine enough for tube-feeding

Here's protein-rich meat that patients on soft, smooth diets can eat and *enjoy!* Swift's specially prepared Strained Meats provide an excellent base for a high-protein, low-residue diet—in a form that is chemically and physically non-irritating. There are six different, highly palatable meats: beef, lamb, pork, veal, liver and heart. These wholesome meats are readily accepted by most patients, even when normal appetite is impaired.

Swift's Strained Meats were developed originally for feeding to young infants. The individual particles of meat are fine enough to pass through the nipple of a nursing bottle—may easily be used in tube-feeding. Swift's Strained Meats are prepared with expert care from selected, lean U. S. Government Inspected Meats, carefully trimmed to reduce fat content to a minimum, and cooked to retain a maximum of the valuable meat nutrients—biologically complete proteins, B vitamins and minerals. Swift's Strained Meats are convenient to use—come ready to heat and serve. Each vacuum-sealed tin contains three and one-half ounces of strained meat.

All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.

Swift's Diced Meats

For patients on a soft, high-protein, low-residue diet who can eat meat in a form less fine than Strained, Swift's Diced Meats offer an excellent, appetizing source of proteins, B vitamins and minerals. Swift's Diced Meats are tender, juicy cubes of meat—offer a variety of: beef, lamb, pork, veal, liver and heart, five ounces per tin.

If you wish samples of Swift's Strained and Swift's Diced Meats together with complete information, write: Swift & Company, Dept. B.F., Chicago 9, Ill.

SWIFT QUALITY FOODS

SWIFT & COMPANY • CHICAGO 9, ILLINOIS

Professional Men Appreciate

*"BOTANY" BRAND 500

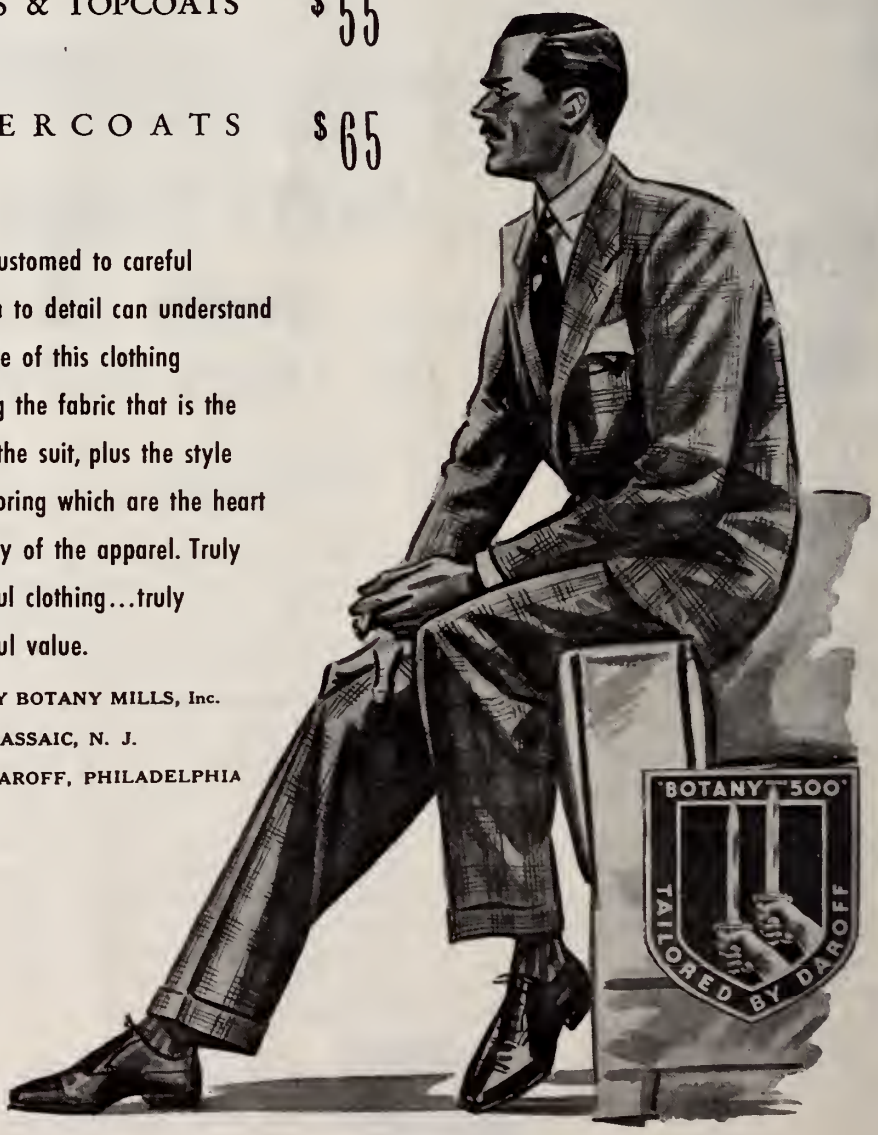
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Men accustomed to careful attention to detail can understand the value of this clothing featuring the fabric that is the soul of the suit, plus the style and tailoring which are the heart and body of the apparel. Truly wonderful clothing...truly wonderful value.

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CAMP design is dedicated to meeting the physiological, surgical and maternity needs of the patient with the utmost in comfort and aesthetic appeal. Each specific design is further refined for the variety made necessary by the multiplicity of body builds and figure irregularities. The unique CAMP adjustment feature establishes a firm foundation about the pelvis as an "engineering" base for the distribution of regulated support. This makes it easy for the fitter to follow with precision the physician's recommendations for indicated firmness about the pelvis and controlled support of the abdomen, spinal column and gluteal region without pressure or compression.

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Camp Anatomical Supports have met the exacting test of the profession for four decades. Prescribed and recommended in many types for prenatal, postnatal, postoperative, pendulous abdomen, visceroptosis, nephroptosis, hernia, orthopedic and other conditions. If you do not have a copy of the Camp "Reference Book for Physicians and Surgeons", it will be sent upon request.

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Babies to Teen Agers



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Whether sturdy shoes for school, play shoes, or dress . . . or corrective shoes prescribed by the physician, Wuensch's have them all. Yes . . . they are moderately priced.

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" . . . a mixture of 3 sulfonamides is significantly less toxic than a mixture of 2 compounds."

— Proc. Soc. Exp. Med. 64:393, 1947.



Polysulfas Suspension Available in bottles of 16 fl. oz.

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The First Triple Sulfonamide Mixture

FOR SAFER SULFA THERAPY

Polysulfas Suspension and Polysulfas Tablets provide equal parts of *Sulfadiazine, sulfamerazine,* and *sulfathiazole* in microcrystalline form. Recent studies confirm the antibacterial potency of this formula and show that:

- it minimizes the incidence of sulfonamide crystalluria,
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Flippin, H. F., and Reinhold, J. G.: *Ann. Int. Med.* 25:433, 1946.

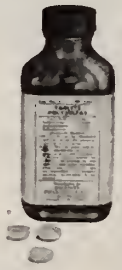
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Lehr, D.: *J. Urol.* 55:548, 1946.

Lehr, D.: *Proc. Soc. Exp. Med.* 64:393, 1947.

Polysulfas Suspension and Polysulfas Tablets are stocked by leading wholesale druggists in New Jersey. Any pharmacist can readily fill your prescriptions.

Sample and clinical literature will be sent to any physician on request.



Polysulfas Tablets Available in bottles of 100 and 1000.

BALDWIN

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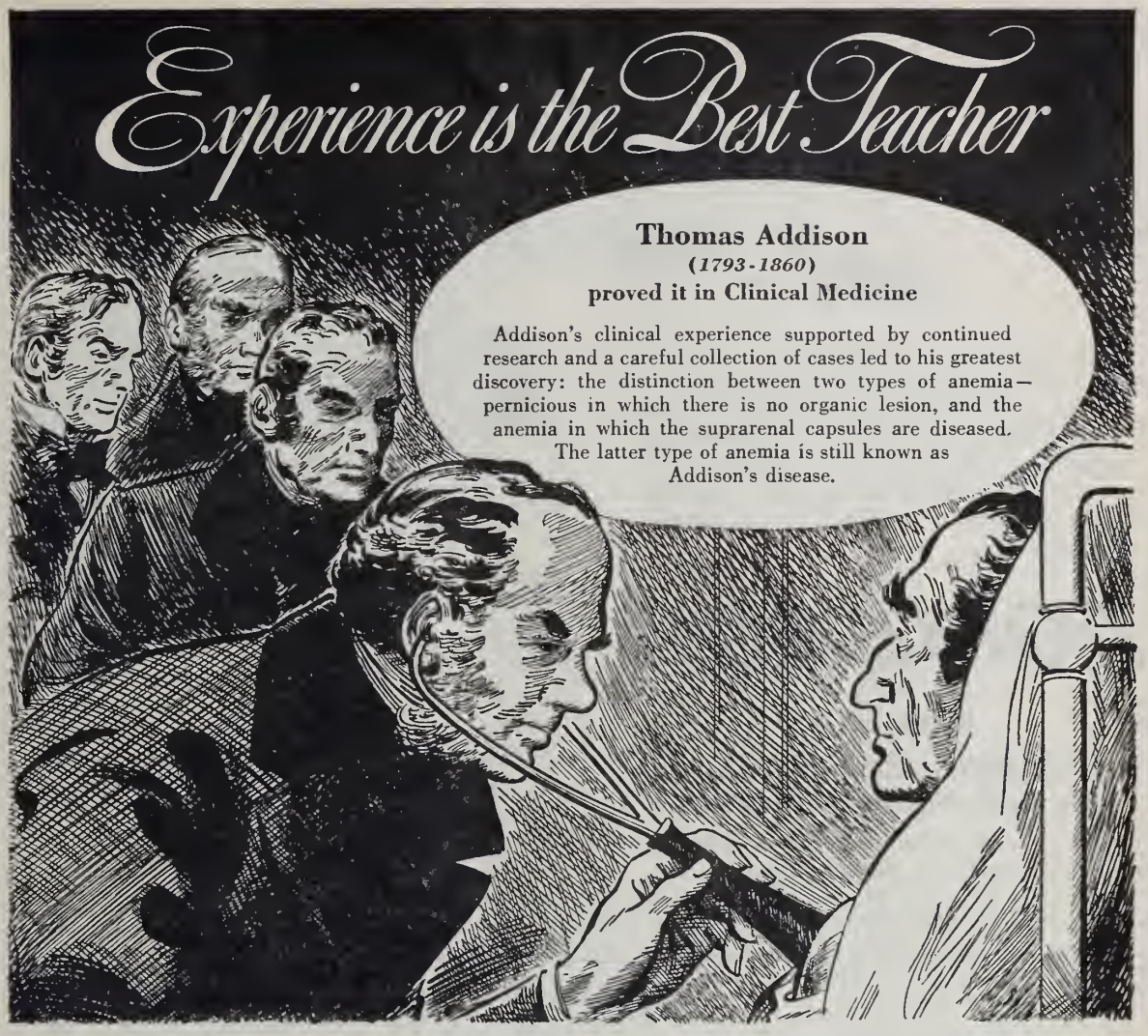
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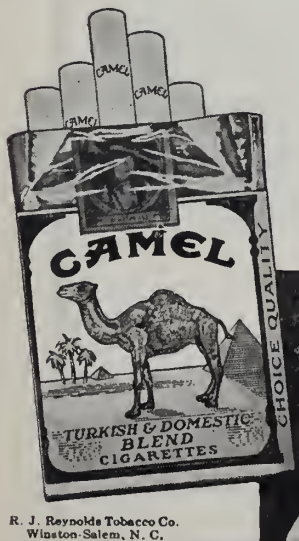
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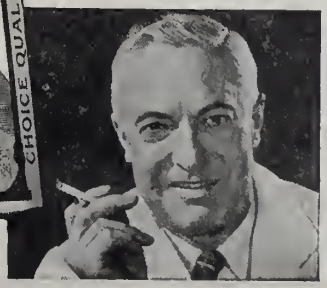
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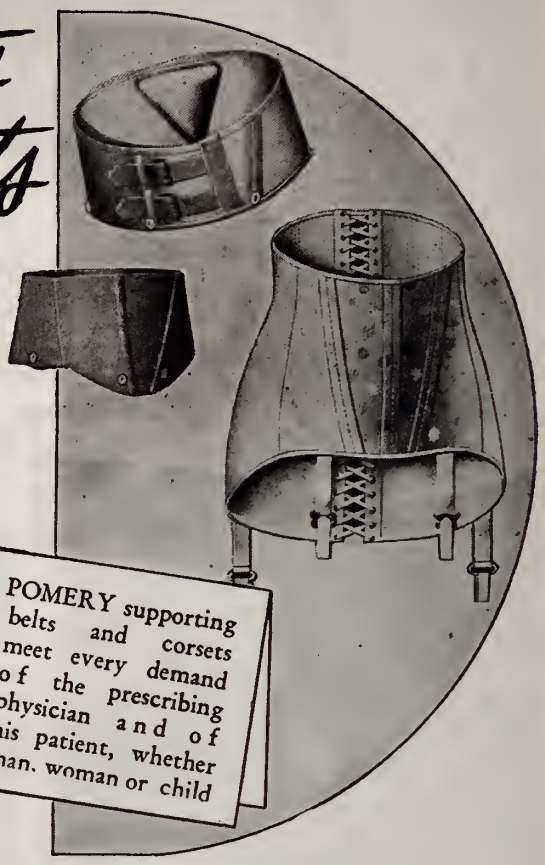
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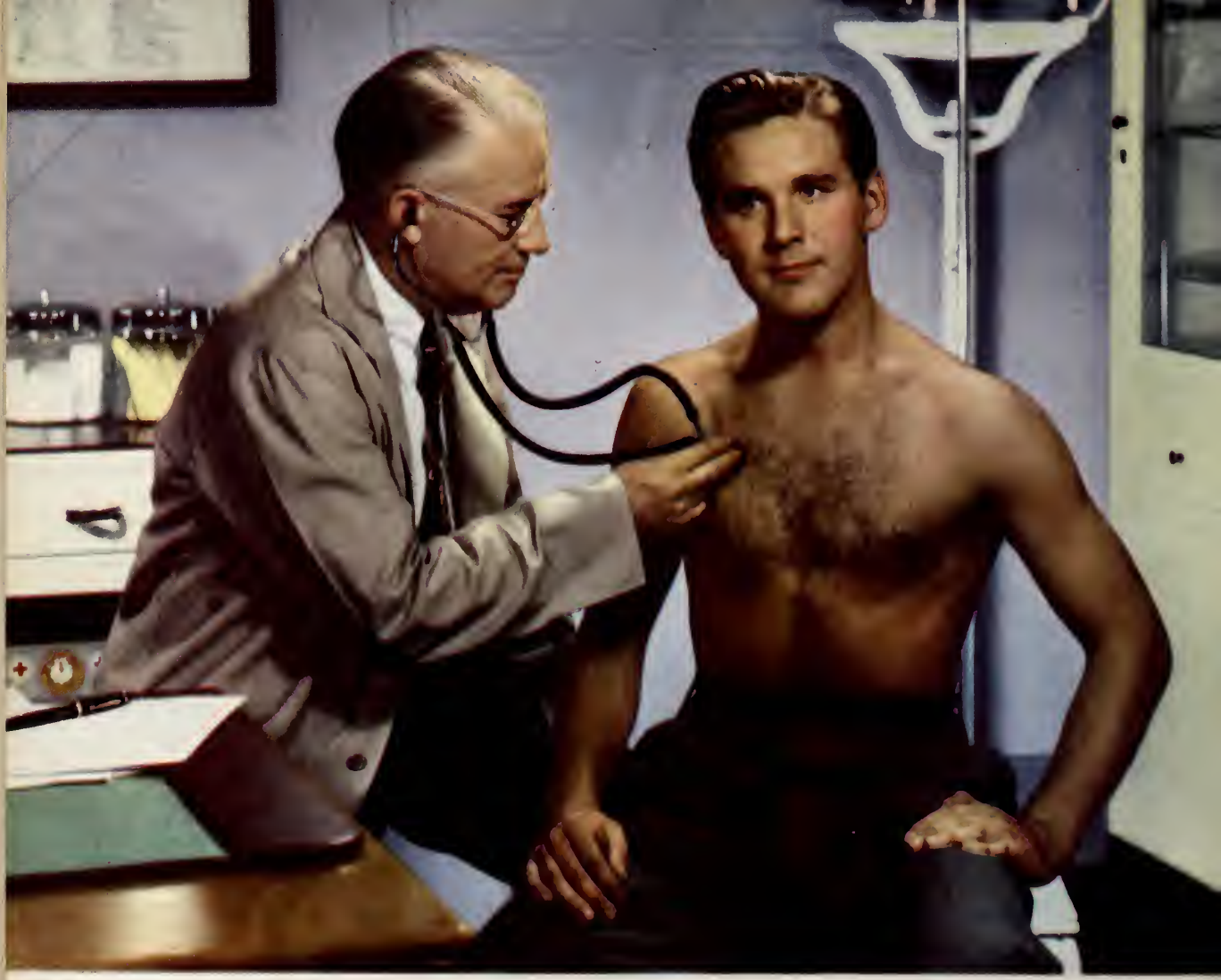
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THE PRESIDENT'S PAGE

STATE SUBSIDY FOR VOLUNTARY HOSPITALS

It is an essential function of a progressive and alert medical society to seek out, and to take the initiative in solving, all important problems affecting the health and well-being of its community. Therefore, The Medical Society of New Jersey, by action of its Trustees, adopted a resolution on November 16, 1947, calling for (1) The subsidizing of nurses training schools under the general direction of Rutgers University (2) Financial assistance from the state in defraying hospital costs for the medically indigent, and (3) An expanding program for the care of beneficiaries of the state Department of Institutions and Agencies. The resolution is published in full on page 507 of this issue.

Nurses training schools in the voluntary hospitals are now supported exclusively by the hospitals that operate them, but they provide most of the professional nurse personnel required by health departments, welfare agencies, schools, industry, visiting nurse associations, and the Veterans Administration. Nursing education is thus a community responsibility, and should be recognized as such.

The Society proposes that part of this burden be taken over by the state, acting through the medium of our State University, if necessary. This would assure high and uniform standards of nursing education and would alleviate, to some extent, the serious financial problem of the voluntary hospital, by providing new revenue for its educational functions.

Our second recommendation is based on the fact that local communities now reimburse voluntary hospitals for only part of the actual cost of hospital care for indigent and medically indigent patients for which the community is legally

responsible. The excess financial burden borne by the hospital is reflected to some degree in the high charges paid by private and semi-private patients. We propose that more substantial state funds be made available to local communities through the existing welfare mechanism to enable them to pay their fair share of these hospital costs. This will afford some financial relief to the private patient, too. The need for substantial aid to our New Jersey voluntary hospitals is indicated by the anticipated total deficit of these hospitals for 1947, which is $2,305,000.

Our third proposal is that the state provide more adequately for the care of long-term or chronically ill patients. New Jersey's facilities for the chronically ill, especially nervous and mental cases, are seriously inadequate.

While these proposals would require the state to raise additional funds, they will (a) produce more and better hospital and nursing service, (b) help perfect and improve our voluntary hospital system, and (c) relieve self-supporting patients in some measure of an almost unbearable burden, much of which is properly a charge against the community at large.

These proposals were discussed informally with representatives of the State Nurse and Hospital Associations before being acted upon by your Trustees. They are strictly in line with a current effort on the part of the Hospital Association to persuade freeholders to provide more adequate funds for local communities to pay charges of hospitals in amounts more nearly approaching the actual cost of care for public cases. Your officers feel that these proposals need and deserve the support of every member of our Society.

Royal A. Schaaf, M.D.
President.

CERTIFICATION FOR GENERAL PRACTITIONERS

The question of who takes care of the care-taker's daughter is highlighted by the recent suggestion of a board to certify family doctors. Of course, if the general practitioner really wants certification, it should be made available. But if the board itself will be composed of general practitioners, how are the examiners to be selected? And if specialists are going to test general practitioners, it seems likely that the diploma will go to the doctor who can give the most scholarly answers, not to the practitioner who can best handle patients.

There is a flavor of arrogance about asking a mature, richly experienced, time mellowed family doctor to submit himself to frequent re-examination. The hard-working general practitioner is everywhere praised as the backbone of American medicine. Are we now to tell him that he cannot treat his own patients in a hospital until he satisfies some self-selected quiz-masters? He has completed four years at medical school, a year or two of internship and has spent a decade or so treating measles, delivering babies, advising cardiacs, nursing pneumonias, applying splints, suturing lacerations, swabbing throats and doing the thousand other chores that come with general practice. Must he now pore over textbooks of physiology and pathology, learn all about pH and Rh, recite the course of the posterior inferior cerebellar artery and reel off a list of chronaxies?

The basic desiderata for a good general practitioner include a fundamental knowledge of medicine and surgery, shrewdness in appraising human nature, the confidence of his patients and prac-

tical experience in the handling of sick people and their families. None of these can be weighed by any board of examiners.

The family doctor has been tested by his medical school and quizzed by the State Board. He has been seen in action by his patients and neighbors, and has been judged of high karat quality in the crucible of experience.

Is the purpose of the examination to determine whether he has kept pace with advances in medicine? Then tests must be scheduled at frequent intervals. Every ten years? No, medicine moves too swiftly for that. Every five years? But that can scarcely keep pace with the breathless tempo of medical progress. At this rate, the general practitioner will have to abandon his patient's bedside at yearly intervals in order to serve as a guest expert at a medical "Information Please." An up-to-date family doctor is most desirable; but enough is enough.

THE NATIONAL BLOOD PROGRAM

One of the most far-reaching peacetime medical projects in history begins this year with the initiation of the National Blood Program of the American Red Cross. It is pointed out that there is an ever-widening need for blood and blood-products in medicine and surgery and that whole human blood is one substance that cannot be produced synthetically. Because of its successful accomplishment of the vast blood program during the war, the Red Cross has been designated as the agency to implement this in peace time. It is planned to furnish whole blood, plasma, serum albumin and globulin, fibrin films and red cell suspensions.

Arrangements for reimbursement for the professional services involved in transfusion will be made locally but the Red Cross will not permit the blood itself to be sold. It is the stated objective of the program to "provide whole blood and its derivatives to the entire nation without charge for the products". Some physicians will balk at this, because they will feel that patients financially able to pay for the products, should not receive them gratis. However, the American Medical Association has already approved of the program since it will not interfere with the proper remuneration of the professional personnel actually rendering the service to private patients. It would be hard in any event, for physicians to oppose a public service project of such scope simply because medical fees might be jeopardized.

The Red Cross gives assurance that they will "work in closest relationship with the medical profession . . . . and that local operations will be undertaken only with the support of the medical society". Nothing more could be asked for by the most individualistic of physicians.

It seems certain that this project will catch the public eye and meet with warm popular approval. Under those circumstances, resistance on the part of physicians, will harm the profession more than it will the program. Some persons, already suspicious of many doctors' attitudes towards health progress, would like nothing better than non-cooperation at this point. It would be loudly acclaimed as evidence of social backwardness on the part of the physicians. Cooperation would seem to be sound not only from the humanitarian standpoint, but also from that of public relations.

ORIGINAL ARTICLES

RECONSTRUCTIVE SURGERY OF THE EXTREMITIES *

John J. Flanagan, M.D., Newark, N. J.

Recent scientific advances have revised the outlook in reconstructive surgery of the extremities. Chemotherapy, particularly penicillin, by preventing or controlling infection, has salvaged many extremities previously sacrificed by amputation. Through control of infection, certain types of reconstructive surgery can be instituted immediately following trauma. The affected extremity can thus be reclaimed while its tissues are still in a relative state of physiologic balance. In the past, following prolonged infection, fibrosis and disuse, saving of the crippled extremity was of little advantage and the patient was permanently handicapped.

During the recent war, with its innumerable casualties, great strides were made in skin, nerve, tendon, and bone surgery. Furthermore, through experience, we have learned that the combined treatment of all the tissues of the extremity, with few exceptions, should be under the care and control of one therapist, whether he be a general surgeon, plastic surgeon, or orthopedic surgeon.

THE ACUTELY TRAUMATIZED EXTREMITY

The acutely traumatized extremity presents a genuine surgical emergency. After the infliction of serious trauma to an extremity, great care must be exercised immediately in the course of the examination to determine the degree and extent of trauma. This is done while the patient is conscious, before the induction of anesthesia, as subjective responses of the digits and joints of the affected extremity reveal the degree of involvement of the muscles, tendons, and nerves. Prompt and routine x-rays reveal the extent of damage to the bones and joints. Shock is controlled by careful immobilization of the involved extremity, replacement of blood loss with whole blood, and control of pain with narcotics. Penicillin is given preoperatively as well as postoperatively.

Under general anesthesia, the extremity is prepared in the usual manner for surgery by shaving and cleansing the skin surfaces adjacent to the wound. Care is taken to avoid the use of antiseptics in the wound itself. Following surgical draping of the extremity, the wound is thoroughly irrigated with several litres of warm saline solution. This removes contaminating debris and blood clots and cleanses the wound for more thorough examination. It is at this time that the operating surgeon, after direct examination of all the tissues finally sums up the degree of damage. He then plans and executes his methods of reconstruction. If greater exposure is needed, it can be obtained by sharp dissection along muscle and fascial planes. If a fracture is present, which can best be immobilized by internal fixation, this is done with the aid of transfixion bone screws or bone plate and screws. Wiring of the bone ends is usually unsatisfactory, as it does not give positive fixation. However, if adequate position and immobilization can be maintained by skeletal traction and plaster cast externally, metallic internal fixation is to be avoided.

If the shaft of the bone is crushed and severely comminuted, care should be taken in the debridement not to remove too much bone substance for fear of resulting nonunion from loss of continuity. In general, small fragments of bone, separated from blood supply through detachment from periosteum and muscles, should be removed. Larger free bone fragments consisting of the entire, or a large part of the circumference of the shaft, should be left *in situ* as free grafts in the hope of establishing bony union.

Damaged nerves are tested by electrical

* Read by invitation, April 22, 1947, at the Annual Meeting of The Medical Society of New Jersey.

stimulation. If not functioning, the crushed portion of the nerve may be resected and the squared nerve ends carefully sutured with fine silk or tantalum wire and placed in a secondary bed of muscle tissue, if possible. If necessary, a gap of two to three inches can be overcome in the main nerve trunks by dissecting the nerve trunks proximally and distally, and flexing the adjacent joints. In repairing a nerve, care must be taken to avoid rotation of the nerve ends in an effort to place the related axis cylinders in direct continuity. Furthermore, the sutures must be placed in close proximity to each other in the neurolemma, not deeply through the axis cylinders. We avoid wrapping the sutured nerve ends in tantalum foil because of secondary contracture of the surrounding cicatricial tissue and strangulation of the nerve.

Damaged muscles and tendons are then carefully identified and repaired. The tendons are sutured with fine silk or wire. Wire, if used, is inserted in such a manner that it can be extracted, in approximately three weeks, by pull-out wires according to the Bunnell technic.

Immediately before the wound is closed, it is again thoroughly irrigated with litres of warm saline. Penicillin, (200,000 units in four cubic centimeters of saline) is placed in the wound after the irrigating solution has been removed by suction.

Of great importance following repair of the deep structures, is the primary closure of the wound. If the skin margins cannot be completely closed or if closure is accompanied with tension, medial and lateral longitudinal counter incisions may be utilized. The residual defects left by the counter incisions are immediately covered with split thickness skin grafts obtained with the aid of a dermatome. If skin substance has been lost, the use of a local skin flap to cover the wound area is ideal with covering of the residual area left by the skin flap with split thickness graft. If the wound does not lend itself to either of these types of closure, a direct split thickness skin dressing over the wound will assure primary healing. Multiple perforations of the skin dressing with external wet dressings, prevent collection of tissue fluids beneath with resulting death of the skin graft.

In cases of serious and violently acute trauma to an extremity, where there is actual loss of bone substance (as is often seen in motorcycle and airplane crashes) we are confronted with the more difficult problem of preventing shortening by maintaining normal length of the extremity. This is particularly important in involvement of the lower extremity since equality of leg length is so essential in locomotion. In the femur, following repair of the soft tissues and primary closure, length can be maintained by skeletal traction in balanced traction suspension. In loss of bone substance of the tibia, (if the fibula is intact) bone length can be maintained by this internal splint. If the fibula is also involved, length can be preserved either by skeletal traction in balanced suspension or by skeletal traction and countertraction pins. These pins are inserted through the tibia below and above the site of compound wound and bone defect with incorporation of the pins in the external circular plaster cast. In the latter method, after repair of the compound wound and primary closure, the patient may be ambulatory with crutches as soon as the wound heals.

In severe trauma of the upper extremity, with loss of bone substance, the problem is somewhat different. The main function of the upper extremity is motion, not weight bearing. Loss of bone length, therefore is not so disabling functionally, though it may be disturbing from a cosmetic standpoint. Therefore, in the immediate repair of acute compound fractures of the upper extremity, either the humerus or both bones of the forearm may be shortened as much as two inches and fixed internally with primary closure of the wound. Under these circumstances, the outlook is for reasonable return of function of the extremity following bony union through reconditioning with physical and occupational therapy.

Bone length of the humerus may be maintained by use of the hanging cast, while length of the forearm can be preserved by traction and countertraction pins through the lower end of the radius and upper end of the ulna incorporated in the external plaster cast.

In these instances, if there has been actual loss of bone substance, subsequent bridging of the bone defects can be instituted in ninety days after the primary healing of the compound wound. Prior to chemotherapy, such reconstruction of bone was never attempted in less than six months after healing of the wound. Many of these latter cases were doomed to failure through relighting of the dormant infection and sloughing of the bone grafts.

THE CHRONICALLY HANDICAPPED EXTREMITY

While the proportion of successful primary healing of wounds is very high following care of the acutely damaged extremity, failures do occur, because of inability to control infection, inadequate immobilization, or impaired circulation. Many seriously damaged extremities are accompanied by severe internal traumata or by head injuries, the treatment of which may take priority in order to preserve life. In such instances, delay in caring for the damaged extremity results in additional and prolonged disability. Thus we are often confronted with problems of reconstructive surgery in the chronically involved extremity.

Reconstructive measures cannot be undertaken in the presence of chronic osteomyelitis. Confronted with thousands of combat casualties, with disabled extremities complicated by chronic osteomyelitis, we learned that the infection could be quickly controlled by saucerization of the affected bone followed, in seven to ten days, by split thickness skin grafts. In this manner, wounds which had been draining for many months in the early part of the war, were almost miraculously healed and bone infection arrested in four to six weeks. Following arrest of the infection, if further reconstructive surgery is required, these split thickness grafts are replaced by full thickness local skin flaps, pedicle or tube grafts.

RECONDITIONING THE PATIENT

In treatment of the chronically handicapped extremity following elimination of infection and repair of the skin defects, physical reconditioning of the patient, as well as of the involved extremity, are as important as the reconstructive surgery which follows. The success of the reconstructive surgery is in direct ratio to the physical condition of the patient and of the extremity at the time such surgery is undertaken. Physical debility is treated with whole blood transfusions, high caloric, high protein diets, and supervised graduated exercises. Following the healing of the compound wound, plaster immobilization is removed and a supporting brace applied to the affected extremity. Intensive physical therapy and occupational therapy are utilized preoperatively for the purpose of mobilizing the adjacent joints, improving circulation and muscle tone, and the physiology of the affected bone itself. Motion at the site of nonunion is not harmful inasmuch as the bone ends are deeply embedded in dense fibrous tissue.

In importance of sequence, following control of infection, skin plastics, and reconditioning, the damaged nerves receive primary attention followed by tendon reconstruction, and finally bone graft surgery. While nerve surgery can be instituted in thirty days following control of infection and skin plastics, it is best to wait sixty days for tendon surgery and ninety days for bone surgery in the chronically handicapped extremities. Otherwise, even with chemotherapy, there is danger of reactivation of the old infection.

In irreparable damage to nerve trunks, the most commonly involved were the peroneal and radial nerves. In permanent foot drop, transplant of the posterior tibial tendon to the dorsum of the foot is accomplished with fair success. Complete radial nerve paralysis is treated with transplant of the flexor carpi radialis into the long abductor and extensor of the thumb, transplant of the flexor carpi ulnaris into the common extensors of the fingers, and transplant of the insertion of the pronator teres into the radial extensors of the wrist. The result of this operation is most gratifying in terms of regaining extensor function of the fingers, thumb, and wrist.

Through the indefatigable efforts of Sterling Bunnell, great knowledge and experience have been gained in reconstructive surgery of the hand. Where flexor tendon function is lost between the transverse palmar creases and

the distal finger joints, the impaired tendons must be removed and replaced with tendon grafts. These grafts are most commonly obtained from the palmaris longus tendon of the forearm and dorsal extensor tendons of the toes. If necessary, one of the uninvolved flexor sublimus tendons of the fingers may be used. Many muscle bellies are available in the forearm as motors for these newly grafted tendons. Where certain muscle bellies of the forearm are destroyed by trauma, the tendons of these destroyed muscles can readily be transplanted into adjacent tendons motivated by normal muscle bellies.

In bone graft surgery of the upper extremity where nonunion exists without bone defect, following freshening and apposition of the bone ends, the use of an onlay cortical graft from the tibia, fixed with four bone screws, will usually insure union providing the affected bone or bones are immobilized for a sufficiently long period—usually twelve to sixteen weeks. Use of cancellous bone to pack around the site of nonunion will insure additional osteogenesis. In nonunion of both bones of the forearm, where cortical onlay grafts are used, all cancellous bone and even some of the cortical bone thickness is removed from the grafts to provide less bulk in the tissues. A bed is prepared for the graft by denuding a thin layer of cortex from both fragments at the site of application of the graft. If the case permits, the use of a transfixtion screw across the fracture site, engaging both fragments, aids in more positive fixation of the fragments. When a defect is present in one of the bones of the upper extremity, the use of dual grafts of tibial cortex, with packing of the interspace with cancellous bone as described by Boyd seems to be the best method of bridging the defect. Our experience with fibular grafts for bridging of these defects, has been disappointing as the grafts are brittle and take longer for revascularization and successful grafting; and they fracture more readily on strain, particularly torsion of the shaft.

Postoperatively, the grafted humerus is immobilized in a shoulder plaster spica including the trunk, while the grafted forearm is immobilized in a long circular cast from the base of the fingers to the axilla with the elbow flexed to ninety degrees and forearm in complete supination.

In the lower extremity, in nonunion without bone defect, an onlay graft with apposing bone plate for stability is very satisfactory. The sliding onlay graft with stabilizing bone plate is a good procedure in the tibia. For nonunion with bone defect in the femur or tibia, either the dual cortical graft of Boyd or the apposing half cylinder grafts from the affected bone produce excellent results. In the femur, following bone graft, fixation by skeletal traction suspension is preferable to the hip spica cast, as angulation, due to contracture of the abductors, is prevented in traction and early reconditioning of the extremity is possible. In the tibia, a long leg circular cast is the most effective form of fixation, changing to a long leg walking cast when union is stable.

As a substance for bone grafting, iliac bone has a remarkable high osteogenic property and is ideal in selected cases. However, being cancellous bone, it is not sufficiently stable to withstand the stress of providing internal fixation in comparison with cortical bone from the tibia. When internal fixation is provided by a single onlay cortical graft or metallic bone plate, iliac bone blocks or chips accelerate positive bone union.

CONCLUSIONS

1. With the advent of chemotherapy, particularly penicillin, infection in compound fractures can be successfully controlled or prevented.

2. By control of infection, many extremities previously sacrificed by amputation can be saved with reasonable outlook of return of function.

3. Through the medium of split thickness skin dressings or local skin flaps, when indicated, even the most severe compound wounds can be closed primarily, immediately following debridement and repair of the deep structures.

4. With reasonable assurance of control of infection and primary closure of wounds, certain types of reconstructive surgery may be instituted immediately following the infliction of trauma. Thus the affected extremity can

be rehabilitated in a much shorter period with outlook of more complete return of function.

5. Maintenance of bone length is most important in reconstructive surgery of the lower extremity, while maintenance of motion is the prevailing factor in reconstruction of the upper extremity.

6. In treatment of the chronically handicapped extremity, preoperatively, reconditioning of the patient and affected extremity is considered as important in the final outcome as the reconstructive surgery which follows.

7. Reconstructive surgery of trauma, acute and chronic, is most effectively accomplished through the efforts of one treating surgeon whether he be a general surgeon, plastic surgeon, or orthopedic surgeon. This is the science of the surgery of trauma.

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173 Roseville Avenue

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HONOR TO DR. HYMAN GOLDSTEIN

A recent issue of the *Review of Gastro-Enterology* has been dedicated to Dr. Hyman Goldstein of Camden, N. J., on the occasion of his 60th birthday. Greetings from his friends and colleagues and from many of the nation's leading gastro-enterologists are included in this special number. Dr. Goldstein is a member of The Medical Society of New Jersey, through the Camden County Medical Society, and his fellow-practitioners in New Jersey join with his colleagues in the National Gastro-Enterologic Association in felicitating him on this birthday.

NEW ANESTHESIA JOURNAL

A new British periodical, called *Anaesthesia* has just been released. The sample issue which was sent to our editorial office is a 50 page pocket-size booklet which includes one editorial, several abstracts from the current literature, a page of association news, and seven original articles. It is a quarterly, and annual subscription is presently two British pounds, though it is hoped to reduce this rate when the circulation increases. Write to The Anaesthesia Publishing Office, 24 Thayer Street, London, (W-1) England, for subscriptions and further details.

PRIMARY ATTACK OF BENIGN TERTIAN MALARIA FOURTEEN MONTHS AFTER CESSATION OF SUPPRESSIVE THERAPY

Irving L. Sperling, M.D., Newark, N. J.

With the discharge of millions of soldiers and sailors, malaria has become a fairly common disease in private practice. Most of the cases are those of recurrent malaria, chiefly of the *Plasmodium vivax* (benign tertian) type. This tends to produce recurrent attacks with the period lengthening between attacks until the disease subsides, usually within a period of three years.[1] Frequently the interval between the initial attack and the second attack may be prolonged as much as several months. However, the interval from inoculation (or from cessation of suppressive therapy) to the first attack is rarely more than two to four weeks and often less. The incidence of reports of delayed primary attacks extending past a few months is so small that the following case with a primary attack apparently occurring fourteen or more months after exposure is herein recorded.

CASE REPORT

The patient was a 24-year-old white student, first seen on February 18, 1947, with complaints of severe frontal headache and fever of two days duration. These complaints began on February 16. The following morning he was asymptomatic and was able to attend school. He was well until February 18, at which time he had a temperature of 105° with a marked frontal headache and mild backache. There were no chills or other symptoms. Physical examination was essentially normal and he was treated symptomatically with salicylates. The following day he was asymptomatic and continued well until February 20 when he again had sudden onset of a temperature of 105°, with severe headache. Again the examination was noncontributory. Blood count on this date revealed 5,750 leucocytes, with a differential count of 45 polymorphonuclear leucocytes, 35 stabs, 14 lymphocytes and 6 monocytes. Smear was positive for *plasmodium vivax,* and atabrine therapy was instituted. In 24 hours the symptoms receded and he became afebrile. On February 28 he was completely asymptomatic and the blood smear was negative.

This patient has always lived in the eastern part of the United States and never travelled until his induction into the army, in 1944. In June of that year he was transferred to Blak, a strongly endemic malaria area in the Dutch New Guinea group. He took atabrine in doses of 0.2 Gram daily, and this was continued faithfully until December 3, 1945, when he embarked for the United States. He remained on active duty until December 6, 1946, when he was discharged from the army. During this period he was stationed in New Jersey except for a period of six weeks in Lousiana in the spring of 1946.

There was no history of any previous illness nor were there any recent complaints suggestive of subclinical malarial attacks.

DISCUSSION

Reports of delayed primary attacks of malaria are as yet fairly uncommon in the literature. This of course is due in part to the short period of time which has elapsed since the return to civilian life of most veterans with malaria, and consequently the meagreness of reports of these cases.

A review of the literature reveals very few cases of delayed primary attacks of benign tertian malaria prior to the recent war. In the older reports there were instances of delayed attacks with *plasmodium malariae,* which normally is the most persistent type, and of *plasmodium falciparum.* However, there were no cases of delayed benign tertian malaria in the older literature.

Recently Cavenough[2] reported a primary attack of malaria six months after cessation of suppressive atabrine therapy and departure from an endemic area. Coggeshall[3] also cited a similar case occurring eight months after cessation of suppressive therapy. Scheifley[4] recently reviewed the literature and was unable to find any greater incidence. He reported a primary attack of malaria twelve months after stopping suppressive therapy. London *et al.*[5] recently reviewed 101 cases of delayed primary attacks of *vivax malaria.* They found a mean interval of 41 days between the end of atabrine (or quinine) suppressive therapy

1. Strong, R.: Stitt's *Diagnosis, Prevention and Treatment of Tropical Diseases.* Blakiston, Philadelphia, 1943.
2. Cavenough, R. L.: Bull. U. S. Army Medical Dept. (no. 83) p. 120 (Dec.) 1944.
3. Coggeshall, L. T.: Am. J. Trop. Med. 25:177 (May) 1945.
4. Scheifley, C. H.: Proceedings of the Staff Meetings of the Mayo Clinic. 22:49 (Feb. 5) 1947.
5. London, I. M.; Kane, C. A.; Schroeder, E. F., and Most, Harry: New England J. Med. 235:406 (Sept 19) 1946.

and the primary attack. The maximum period they found was 104 days but they state that it may occur up to a year. This latter impression was previously held by other writers[6] but the literature failed to bear this out with actual case reports.

In the case here reported, there is no evidence of subclinical malaria. Following the return of the patient to the United States he was at all times in a non-endemic area. He did spend a brief period in Louisiana where malaria does exist. However, the risk was so slight that no atabrine was prescribed to soldiers stationed there. If it can be assumed that the primary infection was acquired at that time (April 1946) we would have a primary infection occurring ten months after exposure without suppressive therapy. This in itself is even more unusual than the delay after suppressive therapy and the possibility may be dismissed. It can be assumed that this case is one of a primary attack of benign tertian malaria occurring fourteen or more months after cessation of suppressive therapy.

The apparent rarity of these delayed attacks makes their possibility all the more important. These delayed attacks often present atypical or bizarre symptoms and diagnosis is easily over-looked. Therefore, it is important to think of malaria in these unusual febrile illnesses occurring in a veteran even though the interval may be a year or more.

CONCLUSIONS

1. Delayed primary attacks of benign tertian malaria occurring more than a year after cessation of suppressive therapy are uncommon. Such cases have rarely been reported in the literature.

2. A case of benign tertian malaria occurring fourteen or more months after discontinuing atabrine suppressive therapy is reported here.

167 Osborne Terrace

6. McCoy O. R.: Am. J. Trop. Med. 26:351 (May) 1946.

LONG ISLAND COLLEGE ALUMNI

"Ah, there was good news that night!"—for Jersey alumni of Long Island Medical College. Founded on Armistice Day at a meeting at the Academy which was well attended despite a driving rainstorm, the New Jersey chapter of the Alumni Association of the Long Island College of Medicine got off to a flying start.

Purposes of this new group are to renew old associations, to note the other fellow's protruding abdomen and receding hair-line, and to help the college establish a sixteen million dollar medical center.

Temporary officers elected were: Dr. Henry B. Kessler '05, president, and Dr. John N. Pannullo '18, secretary. Dr. J. Arnold de Veer of the College Alumni Council was guest speaker.

All graduates are urged to communicate with Dr. J. N. Pannullo at 266 Van Buren Street, Newark 5, for notification of future meetings and social events.

FRANK L. ROSEN, M.D., '33

SICKNESS CERTIFICATES FOR RAIL WORKERS

Physicians throughout the nation are often asked to furnish medical evidence to substantiate the claims of railroad workers who may now draw cash sickness benefits under the Railroad Unemployment Insurance Act. The Railroad Retirement Board points out that unless an application is mailed before the seventh day after the first day of sickness claimed, it may not be received within the legal time limit for filing applications. As a result, the employee may lose benefits. Doctors are asked to return each completed statement to the patient, or to mail it promptly to the office of the Board to which it is addressed.

ANTI-Rh SERUM DEVELOPED

The National Institute of Health has approved the anti-Rh (anti-D) serum recently developed by Dr. Philip Levine as an indicator to determine whether an individual has Rh negative or positive blood. A limited supply of the new diagnostic serum has been made available by the Ortho Research Foundation.

DERMATITIS FACTITIA
A PSYCHOSOMATIC DISORDER

H. C. Goldberg, M.D., and Harry Hoffman, M.D., Plainfield, N. J.

The skin is the mirror of the physiologic state of the body. It is also the mirror of the state of the mind. Certain disorders of the skin are primarily caused by emotional disturbances. We will deal in this paper with dermatitis factitia as an example of this type of disturbance. Dermatitis factitia is a disease in which lesions, often leading to scar formation, are produced by the patient. Combined fields are represented in the term psychosomatic medicine. The ideal way to bring out clearly this relationship is by the correlated efforts of specialists in these combined fields.

The present subject has been selected because the dermatologic picture is simple and clear. Psychic factors are regularly present. The cutaneous characteristic of dermatitis factitia is a uniform bizarreness in appearance, with no particular histologic features except for the tears in the skin. The emotional factors may run the gamut of the entire field of psychiatry, but some such feature is always present.

In skin disease the psychiatric element is no less important than in other organ diseases. Important mention has been made of this by Michelson;[1] by Lynch, Hinckley and Cowan;[2] and by Dunbar.[3] Theoretically one might assume that, on an embryologic basis, there would be a close bond between nervous diseases and skin diseases, since both systems arise from the common ectoderm. Certain grossly organic diseases such as von Recklinghausen's with skin and nerve tissue present in the same pathologic process, and adenoma sebaceum with its acne-like skin picture together with mental deficiency, show an organic relationship. Normal functional relationships between the skin and the nervous system become obvious when one mentions blushing, blanching, goose-flesh, itching, and the like.

Yet, in spite of the close anatomic relationship, psychiatric disturbance does not show itself pre-eminently in skin troubles. The stomach, the colon, the heart, the lungs are all utilized to channel off emotional troubles much more frequently than is the skin. In this connection it was interesting to make the comparison between the incidence of skin symptomatology seen in the practice of the psychiatric author (H. H.) of this paper and the incidence of the psychiatric symptomatology seen in the practice of the dermatologic author (H. C. G.). Each of us reviewed 200 consecutive private cases. Of the 200 consecutive patients seen primarily for psychiatric illness, only one and one half per cent presented skin symptoms in addition. The only exclusions made in this series were those seen first by a dermatologist and referred for psychiatric consultation. The three cases might be mentioned briefly. The first was a 54 year old divorcee with a situational depression aggravated by an artificial menopause, showing a dermatitis of extensors of forearms and of the eyelids. The second was a conversion neurosis with paraesthesias of the skin of the back. The third was a manic-depressive depressed patient with preoccupation about inconspicuous hair on face and a dermatitis factitia.

In the series of two hundred consecutive skin patients two per cent were found to have sought treatment for dermatitis factitia alone. This disorder is primarily a psychosomatic manifestation of emotional unbalance. In the series of 200 consecutive psychiatric patients only one and one-half per cent were found to have presented skin symptoms. This may be taken to mean that dermatitis factitia is often found in the milder psychoneurotic personalities, who manage to maintain their social status despite their emotional handicaps.

The following more detailed description of two patients seen originally because of skin complaints and referred for psychiatric treatment illustrates the problem.

1. Michelson, Henry E.: Arch, Dermat. & Syph., 51:245, (April, 1945).
2. Lynch, Francis W. et al: Arch. Dermat. & Syph., 51:251, (April, 1945).
3. Dunbar, H. F.: *Psychosomatic Diagnosis*, New York, Paul B. Hoeber, Inc., 1943.

CASE ONE

This patient was first seen by the senior author in March, 1947. She had had skin trouble for several years with frequent clear intervals. She had had considerable previous treatment. She left her last physician because he "didn't seem interested in her condition". Physical examination was normal except for the skin. The skin of the face, neck and upper back had numerous excoriations, and scars from old excoriated areas. She readily admitted that these came from scratching what she stated were "small red pimples on the skin". Temporary improvement in these conditions is often readily obtained. If relapses occur, or the condition has already lasted over many months, specialized help is necessary. After soothing treatment had been started, she was referred for psychiatric attention.

Psychiatric examination showed a striking coincidence of dermatologic symptoms with emotional factors. She has now been married six years. For the first two years there was a happy adjustment; she lived in an eastern city with her husband and baby under no stressful conditions. Her husband was then transferred to the west. A few months later she followed, only to find very poor living conditions and a husband who had abruptly changed in his personality manifestations to become alcoholic, and neglectful of his wife. He ignored her sexually. Six months after this change in his behavior her skin trouble began. For the next twelve months the dermatitis continued with little change. She then left her husband because of unsatisfactory housing conditions to return east. The skin difficulty remained until shortly after she started an affair with another man. It completely cleared several weeks after satisfactory sexual relations were established. Two years later, her husband returned to live with her. He continued his heavy drinking and remained completely indifferent to her. She discontinued her relationship with the other man. Three months of this indifference brought back the dermatitis in full force. Ten months after the husband's return, with no satisfactory sexual relations for that period, she entered into another affair with prompt improvement of dermatologic signs. We would regard the skin disease in this patient as being firmly connected with the patient's sex life.

CASE TWO

This patient gave a history of an eruption on the scrotum for two years and also complained of being "nervous". Physical examination was normal, except for the skin of the scrotum. Several deeply excoriated areas were seen on the scrotum. His personal history was sufficiently involved to require psychiatric help. This type of patient frequently refuses to see a psychiatrist. He was induced to seek psychiatric help only after several months of treatment.

History revealed that he felt well until April 1944 when, while in the army, he developed a discharge about the glans penis. This upset him considerably. He felt that the discharge had an odor which made the other men of his company shun him. As a result, he became asocial, preoccupied, and unhappy. Three months later he developed a scrotal itch, for which he states he received a "strong medicine" which "burned the skin off". From then on he had a feeling as if there was moisture about the scrotal skin and adjacent thigh surfaces.

A year after the initial discharge began he became so vexed at the failure of Army physicians to pay "proper attention" to his condition that he threatened to refuse to complete his missions as gunner on a large bomber. He was circumcised and states that the discharge went away but that some of the odor still remained. The uncomfortable feeling of moistness remained.

Past History. Enuresis was present till the age of seven, but no other "psychopathologic" childhood traits were present. He was graduated from high school, was employed steadily in an electrical manufacturing company before service, and superficially demonstrated a normal social behavior. Yet he was of a "withdrawing" nature, with few male friends, and with meager female contacts. He has had intercourse a few times only, with prostitutes. Premature ejaculation or frank inpotence resulted with each attempt. After the onset of what apparently was his phimosis he never bothered with the idea of sexual relationships.

Upon release from service he immediately returned to his position as materials checker and made an excellent occupational adjustment. He sought dermatologic help and was receiving it, until referred for psychiatric advice.

Initial psychotherapeutic interviews consisted mostly of explanation which the patient received in a reserved, non-committal manner. Further discussion attempted to outline the importance of the service environment and to elicit the basis of his sexual difficulties. This was without result in effecting any change in his symptoms.

However, two months after psychotherapy was begun the problem of parental relationships was reviewed again. At this point, he changed rather suddenly from a verbally unproductive patient to a loquacious one, showing much bitterness and resentment against both parents. This resentment continued in an unabated form with a continuous outpouring of what was almost abuse against the parents for two more months. Shortly after the beginning of this release he reported much improvement in his skin symptoms. Midway of his abreaction (verbal release of emotional tension) he picked a quarrel with his parents, left the household, and took quarters in a rooming house. Improvement continued. Where he had been using bath and ointment and a powder daily he was now using just the powder twice weekly. The feeling that he was emanating an odor disappeared entirely. Where he had been having an occasional date with a girl whom he regarded indifferently, he was now actively seeking out new female acquaintances. No heterosexual relationships, however, were attempted.

DISCUSSION

The truly dermatologic problems offered by these cases are of school-boy simplicity. A "hands-off" policy by the dermatologist and by the patient constitutes an ample therapeutic regime. In practice strictly bland medication affords adequate dermatologic treatment. To help the patient carry out his part of the "hands-off" policy requires psychiatric help. When this is recognized by the physician, superficial psychotherapy may be adequate. If the response is poor, more intensive psychiatric help should be obtained. Usually chronic cases of this kind automatically indicate a need for specialized psychiatric attention.

Sperling [4] described an interesting case of this sort. Her patient was an eight year old girl who had been having various psychosomatic symptoms for over a year when she then developed another, namely "ulcerations of the leg". This patient required three years of frequent psychiatric treatment to overcome a tendency to produce destructive excoriations due to deep unconscious motivations. In a discussion of this paper [4] Dunbar stated that "unconscious conflicts seem contagious and are often taken over by children from the parents, to be acted out in a physical way". The accident-prone individual may react with this same type of mechanism. This may be of more serious import to society and to the individual since an accident-prone patient is just as likely to reach for an unconscious solution of his conflict by loss of a leg in an accident as another may be by simply excoriating the skin of the leg.

Davis and Bick [5] report marked changes in the configuration of skin lesions in susceptible military personnel under wartime stress. It appears that personal danger, real, threatened or imagined, was always associated with aggravation of pre-existing skin lesions in such individuals.

Mention should be made of *acarophobia,* which is the delusion of parasitosis. Here the dermatopsychiatric factors are again familiar. The patient knows that he is traumatizing the skin. The answer is that he is busy digging out "insects". These patients usually are psychotic and the prognosis poor. Wilson and Miller [6] cite 45 cases of acarophobia. They properly feel that treatment is essentially psychiatric.

PSYCHODYNAMICS

Psychiatric examination reveals involved personality factors and backgrounds to account for self-directed aggressive destructive skin attacks. Horney [7] gives a clear explanation of factors in our culture which tend to produce neuroses.

> Modern culture is economically based on the principle of individual competition. The isolated individual has to fight with other indivduals of the same group, has to surpass them, and frequently, thrust them aside. The advantage of the one is frequently the disadvantage of the other. The psychic result of this situation is a diffuse hostile tension between individuals. This potential hostile tension gradually results in building up of considerable unconscious fear. In our culture, failure and fear of failure involve a frustration of physical needs and prestige and cause emotional unbalance.

Competition and its potential hostilities result psychologically in a feeling of isolationism. This in turn produces an intensified need for affection. Such involved basic facts produce anxiety and destructive impulses. In a neurosis, destructive impulses seemingly may be directed more safely against one's own person than against others. Our contradictory conflicts stem from such cultural ideas as competition and success, opposed to brotherly love and humility; alleged freedom of the individual, and all his factual limitations. The neurosis represents the struggles to reconcile these conflicts of the individual; the tendency toward aggression and toward yielding; excessive demands and fear of not getting anything.

Organicists demand somewhat sharply that a definite mediating mechanism be demonstrated in linking a skin disease with a psychic cause. Many dermatologists will concede a psychic cause only in such obvious conditions as neurotic excoriations and factitial

4. Sperling, Melitta: American Psycho-analytic Association Meeting, 1947.
5. Davis, David B., and Bick, John W.: J. Nerv. & Ment. Dis., 103:503, (May, 1946).
6. Wilson, J. Walter, and Miller, Hiram E.: Arch. Dermat. & Syph., 54:39, (July, 1946).
7. Horney, Karen: *The Neurotic Personality of Our Time.* W. W. Norton, 1937, New York.

dermatitis. They may agree that in other medical conditions, (such as hypertension and peptic ulcer) a state of obvious nervous tension might cause an increased flow of epinephrine or of hydrochloric acid and therefore lead to these "popular" psychosomatic illnesses, though the actual psychosomatic background of hypertension and peptic ulcer may be something entirely different. In thinking of possible psychic factors then of certain skin diseases such as psoriasis and neurodermatitis, where the etiology is not yet known, we should not be guilty of trying to make too obvious a connection between such things as "tension" and easily observed direct consequences in the skin. Only further investigation will bring out the correct mechanism in psychosomatic skin diseases.

CONCLUSIONS

Dermatitis factitia is an easily recognized skin disorder of psychiatric origin. Two cases are reported developed by a dermatologic-psychiatric team for a dermatologic-psychiatric entity.

We have presented *dermatitis factitia* as a psychosomatic dermatosis occurring in two per cent of our dermatologic cases. A still larger proportion comprises all of our psychosomatic dermatoses. A psychiatric point of view is as important in dermatology as in other fields of medicine.

7 Watchung Avenue
805 Park Avenue

SOME NEW JERSEY HEALTH FIRSTS

The *first* state medical society in the western hemisphere, was The Medical Society of New Jersey. It was founded in 1766.

The *first* meeting of the American Public Health Association was held in New Jersey. The date was September 12, 1872, the place was Long Branch.

The *first* session of the National Tuberculosis Association was in New Jersey—in Atlantic City in 1904.

The *first* certified milk commission in the world was established in 1892 in New Jersey. It was set up in Essex County and represented the fruit of the labors of Dr. Henry Coit.

The *first* fully state-wide registry of births and deaths in the U. S. A. was established in New Jersey. This was in 1848—just a hundred years ago.

The *first* tuberculosis preventorium in the country was the one set up at Farmingdale, N. J., in 1909.

The *first* public water supply in the country to get a chlorination plant was the Boonton works of the Jersey City water supply. This was also in 1909.

The *first* death registration area established by the U. S. Census Bureau in 1880, included all of New Jersey.

The *first* state in the union to license health officers and sanitary inspectors was New Jersey. That was back in 1903.

Abstracted from *Public Health News*, 28:415

EMERGENCY OXYGEN EQUIPMENT

Any discussion of "The Use of Oxygen by the General Practitioner" does well to direct attention to the value of early administration of oxygen in acute anoxemic states as Dr. Brenneman has done in his article on page 410 of the October 1946 Journal of The Medical Society of New Jersey.

Administration of oxygen at the earliest possible moment requires that the oxygen arrive with the physician. I have achieved this by keeping a face mask, the gauges described by Dr. Brenneman and two 150-gallon tanks of oxygen available in my office to carry with me to the scene of any anoxemic emergency. The water bottle is omitted.

One learns to sense when to expect an anoxemic emergency from the incoming call. I have repeatedly used this equipment in coronary occlusion earning the gratitude of the patient by relieving pain and oppression, clarifying the differential diagnosis, and, I believe, diminishing the extent of the muscle damage if not actually achieving the saving of life.

Other doctors have found an emergency supply of oxygen equally worth while in other acute anoxemias.

Any physician who has wanted oxygen immediately in an emergency will do well to consider assembling such an outfit. When he alone uses it, he may prefer to store it in his car rather than his office.—Wm. Courtney Douglass, M.D., Bernardsville, N. J.

MASS X-RAY SURVEY IN BURLINGTON COUNTY

Alexander Krasnitz, M.D., New Lisbon, N. J.

At the request of the New Jersey Department of Health, a mass chest x-ray survey was conducted in Burlington County during the summer and fall of 1946. Primary purpose of this project was to screen out cases of pulmonary tuberculosis. We used 70 millimeter films. The apparatus was a photofluorographic mobile Westinghouse unit. In all, 4553 films were read. Interpretations were made by Dr. Marcus Newcomb, Dr. Samuel Busansky, and the author. The survey was divided into separate projects, each project being the study of the chests of the employees or inmates of a single agency, plant or institution. Films were read with the aid of an electric viewing box made by the Westinghouse Company. Of the 4553 films only 20 were unsatisfactory for reading. Static was the major difficulty.

GENERAL FINDINGS

The general findings may be grouped as follows:

Total persons x-rayed		4553
Excessive calcification		374
Old pleurisy		51
Silicosis or pneumoconiosis		3
Tuberculosis (definite or suspicious)		55
Definite	16	
Suspicious	39	
Cardiac findings		156
Enlargement	29	
Valvular	8	
Mediastinal	82	
Aneurysm or aortitis	8	
Prominent aortic knob	29	
Anatomic Anomalies		26
Scoliosis or curvature	16	
Cervical rib	5	
Rib anomalies	4	
Azygos lobe	1	
Atelectasis		1
Displaced mediastinum		1
Emphysema		2
Empyema, old		2
Enlarged hilar shadows		2
Enlarged glands (hilar or mediastinal)		12
Foreign bodies		2
Fractured rib (old)		1
High diaphragm		2
Hodgkins disease (suspicious)		1
Honeycombing (basal)		1
Interlobar septum		3
Linear scars and shadows		8
Malignancy (suspicious)		2
Mass in breast		1
Mediastinal tumors		2
Opacities, miscellaneous		12
Pleural plaque		1
Pulmonary fibrosis		1
Resected ribs		4
Shadow in c-ph angle		1

PUMONARY TUBERCULOSIS

All told, we found 55 cases of active or suspicious pulmonary tuberculosis. This represents 1.2 per cent of the persons examined. In some cases when we returned these subjects for re-x-ray with 14 x 17 films, we found that they really had old arrested or healed lesions. Four cases which were labelled "suspicious" on the 70 millimeter film have been read as "negative for activity" on the 14 x 17 film. How many of the 55 are active cases is not known at present, since twenty of them refused to return for re-x-ray. Three survey patients were admitted to Fairview Sanatorium, and one to Glen Gardner. Two active cases are under the care of private physicians, and one keeps on working. Of the 39 "suspicious" cases, eight were known to the local Tuberculosis League.

A fairly good guess as to how many of the 55 are active would be to divide this figure by three. This figure of 1/3 active of total chronic cases has been arrived at by Dr. H. R. Edwards[2] of the New York City Board of Health, and checks with other surveys[3] throughout the nation. We therefore should expect about eighteen active cases.

The term "suspicious" as used in this survey, should not be taken in its literal sense. In some cases, the word "suspicious" was applied even though it appeared to be a definite case of pulmonary tuberculosis. This was done for several reasons: (1) to avoid frightening the people by telling them they had def-

1. Read, by invitation, to Burlington County Medical Society, February 13, 1947.
2. Edwards, H. R.: In the February 1, 1945, issue of the *New York State Journal of Medicine.*
3. Dempsey, Mary: American Review of Tuberculosis, 48:58, (Jan. 1943).

inite tuberculosis before they had the regular 14 x 17 x-rays, and before one could tell whether they were active. (2) To avoid making a definite diagnosis of tuberculosis, for this was not the purpose of the survey. These 70 millimeter films *are good for screening purposes only and not for any diagnosis.* (3) In some cases the findings were suspicious only of "possible pulmonary tuberculosis".

Some of the "definite" tuberculosis cases were known as former Sanatorium patients, or as chest clinic patients, and some of them showed lesions which could not be mistaken for anything else. Of the sixteen who were called "definite" tuberculosis, four had old fibrotic lesions which were thought to be inactive. One was called an active case because he was a recent patient at the Sanatorium and his film was recognized.

It may be of interest to note that in the two Burlington County institutions, The Welfare Home and the Asylum, only two fibrotic inactive cases in each institution and one suspicious case of questionable activity were found. Due credit should be given to the physicians in charge of these institutions.

CALCIFICATION

Only cases that had excessive calcification (or calcified nodules) in places other than the hilar region were noted, i.e., apices or bases, or in some cases scattered calcification throughout both lung fields as might result from an old hematogenous infection. Calcification resulting from an old healed tuberculosis of the adult re-infection type, rather than the frequent and usual calcification resulting from childhood infection was of special interest. All told, 374 cases with excessive calcification were noted. It would, however, be unfair to blame all this on the tubercle bacillus. Calcification may also be caused by fungi, prominent among which are the histoplasma capsulatum, and the coccidiodes immitis, causing pulmonary histoplasmosis and coccidioidomycosis respectively. Coccidioidomycosis [4] is endemic in California, Arizona and New Mexico. Histoplasmosis is relatively frequent in Tennessee. In certain parts of Tennessee more children react to histoplasma capsulatum antigen than to tuberculin and show calcification.

PLEURISY

In 51 cases, evidence of old pleurisy was found. One was a case of pleurisy with effusion. Here again this is important from the point of view of tuberculosis control, for (although there are cases of streptococcic pleurisy) most cases of primary pleurisy are due to tuberculosis. Therefore old pleurisy must be watched as a more likely potential case of pulmonary tuberculosis, than one without any evidence of pleurisy.

PNEUMOCONIOSIS

Three cases suspicious of silicosis or pneumoconiosis were found. One was in a pulverizing plant, one in a pipe and machine company, and one in the Burlington County Welfare Home.

CARDIAC FINDINGS

Now to mention briefly some other conditions which were found in the survey. By far the largest is the group that was called "cardiac" totaling 156. This is not surprising considering that there were a few octogenarians (one 88) in this survey. Thirty-five patients had cardiac enlargement alone or in combination with mediastinal enlargement. Those that are listed as "valvular" showed mostly prominence or bulging in the mitral region, with or without enlargement. Eight such cases were noted. One returned to the Sanatorium for a re-x-ray and showed marked cardiac enlargement, prominence in the mitral region and had a history of rheumatic fever.

Four cases suggestive of aneurysm of the aorta and four of widening of the aorta and mediastinum were noted. Prominent aortic knobs were found in 29 cases. Perhaps they may be discarded considering the age group. There was no follow-up of cardiac cases though whenever possible these were referred to their physicians for further study. A considerable number also showed mediastinal enlargement, which may also be attributed to the older age group (60 - 80 and over). All told, 93 such cases alone or in combination with cardiac enlargement were found.

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4. Christie, A., and Peterson, J.: American Journal of Public Health, 35:1131, (1945).

ANATOMIC ANOMALIES

Under "anatomic anomalies" we listed: scoliosis, cervical ribs (five cases, one with bilateral cervical ribs), bifurcated ribs or other anomalies of ribs.

Under "miscellaneous" we have listed such conditions as old empyemas, evidence of resected ribs, foreign bodies, indefinite shadows in the chest, pulmonary or extra-pulmonary, and not considered due to tuberculosis; emphysemas, pulmonary or mediastinal tumors, and one case of pulmonary atelectasis (case previously known to us).

COMPARISON OF LARGE AND SMALL FILMS

We were curious to know how the interpretation of the 70 millimeter films compared with that of the regular 14 x 17 films.

Up to date, twenty of the fifty-five cases of "suspicious" or "definite" tuberculosis refused to come for re-x-ray. Then there are 32 more on whom re-x-ray was recommended for reasons other than tuberculosis, and who never returned, and twenty-one cardiac cases recommended to their physicians.

In four cases, tuberculosis was suspected which was not substantiated on the 14 x 17 films. Then there were two cases which proved to be old healed tuberculosis and which were not diagnosed as such. No diagnosis was made in one, and the possibility of an artifact was considered in the other. We believe, however, this is not a serious error considering that the abnormal condition was recognized and re-x-rays were recommended. Even if we should include the last two as errors, we have a margin of two on the side of diagnosing tuberculosis where it does not exist rather than missing it where it does exist. One case, tentatively listed as "suspicious of Hodgkin's or other glandular pathology" proved to be an old healed glandular tuberculosis. However, the statement "or other glandular pathology" partly vindicates this misdiagnosis. Thus the ratio of error is six out of 35 or 17 per cent. Results might be better or worse if all the desired x-rays were available. Great as this error seems, we must not condemn the 70 millimeter films or the readers, for an attempt at diagnosis was made in reading these films, whereas the purpose of the survey was screening only. Then there is another factor. Sometimes three, four or five months elapsed from the time the survey was done to the time the subject appeared for roentgenogram with 14 x 17 films, and we have seen many curious things happen in such an interval of time—shadows disappear, and even cavities close without benefit of treatment.

SUMMARY AND CONCLUSION

1. Four thousand, five hundred and fifty-three 70 millimeter films were read during the mass x-ray survey in Burlington County in 1946. While the purpose of the survey was screening out cases of pulmonary tuberculosis, non-tuberculous pulmonary pathology, cardiac and miscellaneous conditions were also noted.

2. Fifty-five cases (representing 1.2 per cent of the total) were considered suspicious for pulmonary tuberculosis. This compares with 2 per cent in the New York survey [2] and 2.3 per cent in the Philadelphia war industries survey reported by Elsin, Irwin and Kurtzhalz,[5] and 1.3 per cent of the total x-rayed by the U. S. Public Health Service.

3. One hundred fifty-six cases of cardiac conditions worthy of notice were also recorded. This represents 3.4 per cent of the total. Fifty-one cases of pleurisy or 1.1 per cent of the total were noted, and are considered important from the point of view of tuberculosis control. Although we do not know the exact number of active cases, out of the 55, seven are already known as active cases requiring medical or sanatorium care, and it is reasonable to assume that about 1/3 or about 18 may be found to be active.

4. We have found the 70 millimeter films to be good for *screening purposes only* and not for diagnosis or for detailed study. When comparing the interpretation of 70 millimeter films with 14 x 17 films on a relatively small number of cases that have returned for re-x-ray, we find disagreement in 17 per cent of the cases.

5. Elkin, William; Irwin, Mary, and Kurtzhalz, Charles: American Review of Tuberculosis, 53:560, (August 1946).

Fairview Sanatorium

DIAGNOSIS AND MANAGEMENT OF PELVIC ENDOMETRIOSIS *

Franklin L. Payne, M.D., Philadelphia, Pa.

Endometriosis is a condition in which ectopic tissue possesses the histologic structure and function of uterine mucosa. Two types are recognized; the internal and the external. *Internal endometriosis* or adenomyosis consists of the growth of either circumscribed or diffuse adenomatous lesions in the body of the uterus possibly as the result of ingrowths from the endometrium or of embryologic rests that develop later into endometrial tissue. Adenomyosis is found in about ten per cent of all extirpated uteri and frequently is associated with external endometriosis and uterine fibroids.

Endometriosis externa or pelvic endometriosis, is important to all physicians who treat women. Formerly considered a gynecologic curiosity, it is occurring, or is being recognized, with increasing frequency. About ten per cent of pelvic laparotomies are done for endometriosis, and it is encountered with even greater frequency during operations for other pelvic conditions. Indeed from 25 to 30 per cent of the recent gynecologic abdominal sections reveal the presence of this disease in one stage or another. It seems to have a predilection for the "upper strata" of society for, as Meigs [1] has pointed out, it occurs five times more frequently in private than in ward services.

Endometriosis is a disease of the menstrual life, appearing at any time from puberty to the menopause, and even persisting after the menopause occasionally. More than 75 per cent of the patients who seek aid because of endometriosis are between 30 and 50 years of age. Youth, however, does not mean immunity. Fallon [2] reported that four per cent of his patients with endometriosis were less than 20 years of age. The youngest was only 13. While the diagnosis of this disease is difficult during the early years of menstrual life, it can occur at this time and its recognition and treatment are vitally important to the subsequent health of the patient.

GROWTH CHARACTERISTICS

Endometriosis usually is found in the pelvic cavity, involving one or more of the genital structures or the contiguous pelvic organs. Instances have been reported as curiosities in the gallbladder, the lung and the extremities, probably of hemotagenous origin. Among the theories concerning its origin, the most tenable are those of serosal metaplasia, of embryologic rests and of transtubal implantation, as advanced by Sampson.[3] He pictured the regurgitation of viable menstrual debris through the fallopian tubes and its implantation upon the ovaries or pelvic peritoneum. Each implant takes root and becomes a small island of functioning endometrium. During growth, these islands rupture or leak with dissemination of their contents to other sites, each new implant to become a menstruating organ of its own accord. This tendency to diffuse local dissemination suggests malignancy but it is actually a benign process as suggested by its slow growth, limited invasive power, rarity of metastasis and dependence upon ovarian stimulation. No other benign growth spreads so widely or presents such a variety of pathologic manifestations. The ovaries are the most frequent sites of endometriosis where the process may consist of one or more tiny red or purple blisters on the surface. It may occupy a greater part or all of these structures to produce the so-called chocolate cysts ranging in size from pecans to cocoanuts. Peritoneal transplants appear on either the parietal or the visceral layer, with the pouch of Douglas and the utero-sacral ligaments as favorite spots. Here each lesion may vary from a millimeter to a centimeter in diameter. Many times the implants are multiple, producing an extensive nodulation or beading easily demonstrated on rectal examination. In *cul de sac* infiltration, the posterior vagina may contain tiny nodules which appear to project through the vaginal

* Read by invitation, Annual Meeting, The Medical Society of New Jersey, April 23, 1947.

1. Meigs, J. V.: Annals of Surgery, 114:866 (December 1941).
2. Fallon, J.: Journal of the American Medical Association, 131:1405 (1946).
3. Sampson, J. A.: American Journal of Obstetrics and Gynecology, 4:451 (1922).

wall. These nodules change in color from red through purple to black during different phases of the menstrual cycle. The infiltration may extend into the recto-vaginal septum, producing nodulation similar to that of rectal carcinoma. However, endometriosis does not infiltrate the rectal mucous membrane as does malignancy. The fallopian tubes are moderately frequent sites of endometriosis, and endometriomata of tubal stumps following salpingectomy or tubal ligation are not unusual. Other areas of implantation are the external surface of the uterus, the broad ligament, the umbilicus, the cervix, and laparotomy scars. Umbilical endometriosis usually occurs along with the same condition in other locations, particularly the *cul de sac*. The umbilical lesions are small irregular tumors which change in color and consistency during the different phases of the menstrual cycle. Frequently the navel discharges bloody fluid at the time of menstruation. Bladder endometriosis often is associated with extensive *cul de sac* infiltration. Vesical transplants invade the muscular coats but do not perforate the mucosa. Cystoscopy discloses one or more small projections which vary in color from pale blue to deep purple, depending upon the phase of menstrual activity. They are situated above the interureteric ridge at the base of the bladder and each is surrounded by an area of edema, but no ulceration is present. The appendix is the occasional seat of this condition and any portion of the intestinal tract which lies in or near the pelvic cavity is subject to it. The most frequent site is the sigmoid and rectum where extensive involvement with deep scarring may occur to result in partial or complete obstruction either from acute adherent angulation or actual impingement upon the lumen of the bowel. The fact that the mucous membrane never is penetrated differentiates rectal and sigmoidal endometriosis from malignancy.

ASSOCIATED LESIONS

A characteristic feature of this condition is its frequent association with other pelvic pathology which may overshadow both the symptoms and the physical findings of the endometriosis. It occurs alone in only twenty per cent of the cases while the remainder[4] show one or more complicating pelvic lesions. Uterine myomata predominate in this, for about sixty per cent of the patients with endometriosis have fibroids. Adenomyomata are associated with external endometriosis in more than twenty per cent of the cases, while various forms of adnexitis, of the peritubular and periovarian type, occur with the same frequency. Endosalpingitis with tubal occlusion is rare and the fimbriated extremities usually are open. Uterine retrodisplacement (because of its frequency and its obstructive possibilities) is considered to be an outstanding etiologic factor in pelvic endometriosis. Other allied conditions that may predispose and myomata that impinge upon the cervix and distortion of the cervical canal from angulation, scar-tissue or stenosis.

SYMPTOMS

When endometriosis is accompanied by other pelvic pathology it may be impossible to decide whether the symptoms are due to the endometriosis or to the concomitant condition. Endometriosis alone, however, produces a characteristic group of complaints. These fall into three categories: (1) Pelvic pain, (2) abnormal genital physiology, and (3) dysfunction of the contiguous pelvic organs.

The pain usually is associated with the periods but intermenstrual trouble is fairly common. This interval discomfort is described as a constant ache or "bearing down" sensation low down in the pelvic, the sacral, the rectal or the inguinal areas, greatly intensified by menstruation as a rule. Indeed extreme menstrual pain is experienced by two out of three patients with clinical endometriosis, either as an exacerbation of the interval discomfort or as independent unilateral or bilateral pain that often is referred to the previously mentioned regions.

Abnormal physiology appears as menstrual alterations and disturbances in marital and fertility functions. Half of the patients have prolonged or excessive menstrual periods and

4. Payne, F. L.: American Journal of Obstetrics and Gynecology, 39:373 (1940).

40 per cent of the married patients with endometriosis have never been pregnant. Dysparunia is a frequent complaint particularly if the lesion involves the *cul de sac* and rectovaginal septum or is associated with uterine retrodisplacement, as happens so often.

Distortion of the contiguous visceral function consists largely of rectal and bladder symptoms. Rectal disorders such as pressure, aching, painful evacuation and increasing constipation are enhanced tremendously with each menstrual period. Diarrhea may occur with the periods, but rectal bleeding is rarely if ever due to endometriosis. The customary bladder symptoms are marked urinary frequency, urgency, dysuria and strangury, particularly at the period time but hematuria is rarely a symptom of endometriosis.

DIAGNOSIS

The palpation of densely adherent nodular masses of varying size in both ovarian areas or in the *cul de sac* points to endometriosis. The nodularity is most closely simulated by that of ovarian malignancy and pelvic tuberculosis. In less extensive cases, a clean lower genital tract with a short vagina and tense nodular utero-sacral ligaments is highly suggestive, particularly if the uterus is in adherent retroposition. At times the examiner senses a feeling of thickening that may be described as "fanning of the lower uterine segment". This finding, in conjunction with beaded utero sacral ligaments or *cul de sac* nodulation, is almost pathognomonic of endometriosis. A concise clinical picture of endometriosis follows:

It is most frequent in the fourth and fifth decades, but it may occur much earlier. The patient often is sterile. Pain, menstrual disturbances and extreme dysmenorrhea are the chief complaints. Vesical or rectal discomfort and dysfunction with sacral backache occur commonly and are intensified at each menstruation. In the absence of the stigmata of pelvic infection or the signs of ovarian or rectal malignancy, the presence of (a) adherent uterine retrodisplacement, (b) *cul de sac* nodulation and (c) densely adherent cystic or nodular ovaries means endometriosis as a rule.

TREATMENT

With a disease that occurs at any age from 13 to 63 and one that presents such variation in manifestations ranging from a few tiny implants on the pelvic peritoneum to extensive destruction of both ovaries—a concise outline of its management is not easy. Choice of treatment depends upon the patient's age, social and marital status, the severity of the symptoms, the extent of the disease, the removability of the lesions and the presence of associated pelvic pathology. Since the disease is slow-growing, virtually free of malignant potentialities and frequently compatible with pregnancy and childbirth, conservatism should be the guiding principle in its management. This consists of either periodic observation, the adminstration of certain hormones, irradiation therapy or surgical intervention.

Periodic observation is applicable to two types of problems. The first occurs in the young patient with minimal lesions and few symptoms who has no obvious allied condition to predispose to further implantations. Here an explanation of the situation, medical palliation of the symptoms, and the opportunity for fulfilment of the patient's procreative promise are safe and desirable. The second is seen in the older patient who is approaching the menopause with mild symptoms, moderate involvement and unequivocal diagnosis. Regularly scheduled examinations suffice with the assurance that the change of life will solve the problem, as it must do for endometriosis regresses following the cessation of ovarian function.

Hormones in the form of androgens have definite but restricted indications in both age groups. With minimal or moderate involvement that produces menstrual disturbances or pain, the judicious use of testosterone proportionate may afford temporary relief until the objective (pregnancy in the young, the menopause in the older group) is attained. An additional theoretic indication for androgen therapy is its preoperative use in extensive lesions in the effort to reduce the vascularity and curtail the technical difficulties of surgical removal.

The applicability of irradiation therapy depends largely upon the patient's age and the type of involvement. In the younger group with severe dysmenorrhea or abnormal bleeding accompanied only by *cul de sac* implanta-

tions, a diagnostic curettage and the intrauterine application of a small dose of radium are indicated. Through its temporary effect upon the ovaries, irradiation frequently will relieve the symptoms for months without the induction of permanent menopause. In the older age group, as the menopause approaches, the presence of extensive involvement without ovarian hematomata may produce symptoms which require relief. If uterine or ovarian malignancy is disproved, a menopausal dose of x-ray or radium irradiation will circumvent the need for a major surgical procedure.

Isolated lesions, that do not infiltrate too deeply or extensively (such as endometriosis of the umbilicus, laparotomy scars, or lesions of the bladder wall, or the appendix) should be excised. Infiltrative lesions of the bowel, the *cul de sac* or the recto-vaginal septum should not be excised, for their complete removal entails hazardous bowel resections or the danger of postoperative fistulae. The surgical treatment of extensive endometriosis frequently requires hysterectomy. A supravaginal and not a total hysterectomy should be done because of the great risk of vesical or bowel injury during the latter procedure.

In general, surgical management may be considered under three headings: prophylactic operations, conservative "curative" procedures and radical curative measures. *Prophylactic operations* are done upon young women for whom preservation and protection of menstrual and procreative functions is so important. Minimal to moderate symptoms may be present and examination reveals endometrial transplants either in the *cul de sac* or on the uterosacral ligaments. Evidence of faulty menstrual drainage or of actual obstruction may exist. One senses the urgent need to prevent further progression of the disease. Such an attempt consists of thorough cervical dilatation with the insertion of a cervical stem for drainage. The uterus is freed up and suspended through an abdominal incision. Transplants on the ovaries are fulgurized or excised and a presacral sympathectomy is done. This management frequently is followed by both relief of symptoms and cessation of spread of the disease.

Conservative curative procedures are conducted for young women also. Their symptoms are moderate to severe and preservation of the menstrual and the childbearing function is necessary. Examination discloses the previous physical findings plus obvious ovarian involvement which usually is bilateral. The operation is done as outlined above but, in addition, it may be necessary to sacrifice one ovary and to resect or to fulgurize implants on the other one. This is not a vain effort for it usually is effective in the relief of symptoms and often is conducive to subsequent pregnancy. Conservative procedures are conducted in 85 per cent of the patients[5] under the age of thirty, who are admitted to our clinic for the treatment of pelvic endometriosis. In the next decade (30 to 40 years), the incidence of conservative measures drops to 65 per cent and to 30 per cent in the fifth decade. Most of the remainder receive radical therapy.

The radical curative procedure consists of the removal of both ovaries and usually the uterus. This has been necessary in fifteen per cent of patients under 30 years of age, in 35 per cent of those from 30 to 40, and in 70 per cent of those from 40 to 50. The usual picture of the condition that requires this therapy is that of extreme pain and (or) marked menstrual disturbances associated with bilateral ovarian hematomata and (or) extensive involvement of the uterine ligaments and the *cul de sac*. A second indication for radical therapy is the occasional extensive invasion of the ileum, the sigmoid, the rectum or the bladder. Under these circumstances ablation of ovarian function is just as effective as and much less hazardous than the resection of vital organs.

RESULTS OF TREATMENT

It is fortunate that the incidence of both extensive involvement and intolerable symptoms is lowest in the younger and highest in the older patients, since conservative management is far less important in the latter group. While relief of symptoms from endometriosis is assured by complete ovarian ablation (by irradiation or surgery) this rarely is necessary

in young women and the results of conservatism in this group bespeak its continuation. This type of therapy affords complete relief of symptoms in 80 per cent of the patients while fifteen per cent will be partly relieved.[4] Eight to ten per cent of those who are managed conservatively will require subsequent treatment. This is compensated fully, however, by the freedom from severe menopausal reactions and the preservation of the menstrual and procreative functions.

Pregnancy follows the conservative treatment of endometriosis often enough to indicate this type of therapy whenever it is possible during the childbearing age. Various writers[5, 6, 7, 8] have reported the incidence of subsequent pregnancies to be from ten to thirty-two per cent. The ante-natal courses present few more complications than we see in other patients and most of the pregnancies terminate successfully.

SUMMARY AND CONCLUSIONS

1. Pelvic endometriosis is characterized by a multiplicity of its sites of invasion and a marked variability in manfestations. Most of the lesions occur in the ovaries and the *cul de sac,* but they may involve any of the pelvic structures or the contiguous viscera.

2. It is a disease of early, middle and late menstrual life, with an incidence of approximately 80 per cent between the fourth and sixth decades.

3. Additional pelvic pathology accompanies endometriosis in four-fifths of the cases to obscure its presence and to cloud the diagnostic picture.

4. Chief symptoms of endometriosis are those of local pain, alterations in the menstrual and reproductive processes, and dysfunction of the contiguous organs.

5. Treatment may be routine observation, hormone therapy, irradiation or surgical intervention, depending upon the severity of the symptoms, the patient's age and marital status and the removability and extent of the major lesions.

6. Conservatism, particularly in young patients with preservation of ovarian and if possible, menstrual and procreative functions is justified by the subsequent results.

University of Pennsylvania

5. Payne, F. L.: November 1940 issue of the Pennsylvania Medical Journal.
6. Holmes, W. R.: American Journal of Obstetrics & Gynecology, 43:255 (1942).
7. Lock, F. R.: American Journal of Obstetrics & Gynecology, 52:556 (1946).
8. Scott, R. B.: American Journal of Obstetrics & Gynecology, 47:608 (1944).

PANAMA CANAL ZONE NEEDS PHYSICIANS

Physicians interested in duty in the Panama Canal Zone are notified that several positions are vacant with salaries beginning at $6127 per year for doctors who have had four or more years of practice and $5187 per year for those who have had a shorter period of experience. For further information applicants should write to Chief of Office, The Panama Canal, Washington 25, D. C.

THE TUBERCULOSIS HOSPITAL

The most essential service rendered by tuberculosis hospitals to their respective communities is not primarily the hospitalization of patients, but rather the effective control of this disease. C. J. Stringer, M.D., Hospitals, August, 1946.

PROGNOSIS IN SHOCK

Prognostic criteria of the outcome of hemorrhagic shock in animals are described by Glasser and Page, after venesection studies of 68 dogs. (1) Persistent drop in arterial pressure during hypotension, causing blood to flow back into the animal from a reservoir, indicates small chance of survival. (2) Chance of survival is good when response in arterial pressure to adrenalin after reinfusion approaches preinfusion response. (3) If more than 70% of the blood withdrawn is required during reinfusion to establish arterial pressure of 100 mm. Hg., chance of survival is slight.—Cleveland Clin. Quart. 13:125 (1946).

GRADUATE COURSE IN ROENTGENOLOGY

Announcement is made of an intensive, one-week, graduate course in roentgenology in Philadelphia during the week of February 1, 1948. Tuition fee is $50. For schedule, details and application blank, write to Commission on Education, American College of Radiology, 20 North Wacker Drive, Chicago 6. Illinois.

RELATIONSHIP OF OCCUPATIONAL STRAIN TO RECTAL CONDITIONS

SAUL ZAGER, M.D., Newark, N. J.

The physician is occasionally called upon to decide whether a rectal lesion is causally related to effort or strain at work. If so, such a lesion is compensable under the New Jersey Workmen's Compensation Act. There is only a meagre literature referring directly to this situation. Kessler [1] in a thorough discussion of the abdominal organs does not mention rectal conditions at all. Johnstone [2] raises the question of whether hemorrhoids may be caused by strain, and then pursues the subject no further.

Standard texts [3] review the etiology of certain rectal conditions and indicate their relationship to strain and increased intra-abdominal pressure. More notably mentioned are internal hemorrhoids, external thrombotic hemorrhoids, acute fissure, prolapse and procidentia of the rectum. Bacon [4] specifically mentions as predisposing to hemorrhoids "severe muscular strain such as lifting" and increased intra-abdominal pressure such as "straining from coughing, sneezing and vomiting". In discussing prolapse and procidentia, more particularly the latter, he says ". . . . the main defect seems to be one of stretching out or tearing off . . . . of the normal fascial, muscular or peritoneal supports of the bowel". Under predisposing causes for procidentia, he cites increased intra-abdominal pressure provoked by straining. The onset of an acute thrombotic hemorrhoid after severe rectal strain at stool is familiar to all physicians. Its potential onset after physical effort from lifting does not strain the imagination too greatly.

Authorities have considered procidentia of the rectum as a form of "sliding hernia", and for this reason its parallel to the compensable situation of inguinal hernia, is not too far fetched.

CASE ONE

A male, age 58, consulted me on November 2. On September 27, he was helping lift some heavy pipe and suddenly had a hemorrhage from the rectum. This bleeding persisted for a week. Three days after the initial hemorrhage, he noticed that his rectum "came down" with moving his bowels, requiring manual replacement. He had severe pain at every bowel movement, which lasted for an hour afterwards. It was usually associated with much bleeding. He had seen the company doctor several times, but no specific treatment was given. He had been with the company for over three years and had worked without loss of time and with no complaints. There was no history of any previous rectal trouble.

Anoscopy disclosed large internal hemorrhoids. On proctosigmoidoscopy I found redundant mucosa mildly inflamed at the caudal portion. The patient was not able to demonstrate the prolapse on straining on the table, and was sent to the bath room where on attempting to move his bowels he protruded a mass about the size of a clenched fist, which was diagnosed as procidentia of the rectum.

The insurance carrier refused to assume responsibility for the condition and the case was brought up in court where the commissioner directed that the carrier assume responsibility for the necessary operation. Operation was performed, and on supplementary hearing three months later the patient was awarded temporary disability for the entire time lost since the date of the injury and total permanent disability of 7½ per cent.

CASE TWO

A male, age 26, was referred to me by an insurance carrier, with the following history. He had been lifting 500 pound blocks. His assistant "gave way", and he held all the weight himself. He felt something "give way" in his rectum. On applying toilet tissue, he noted bleeding and quit work. He was treated by his family doctor once, who recommended suppositories, and was out of work two weeks during which time he had some pain, bleeding and protrusion on bowel movements. These symptoms persisted until the time of this examination. He denied ever having had any previous rectal symptoms. Inspection showed a redundant prolapsing combined hemorrhoid, and on straining, other hemorrhoids appeared.

In view of the history, I recommended that the carrier assume responsibility for the condition.

CASE THREE

A male, age 37, was seen with the complaint that he was pulling on a heavy wrench at work and felt a burning pain in the rectum. His employer sent

* Read by invitation before the New Jersey Proctologic Society, February 18, 1947.

1. Kessler, H., H.: *Accidental Injuries.* Lea and Febiger, 1931.
2. Johnstone, Rutherford B.: *Occupational Diseases.* Saunders, 1941.
3. Such as Buie, Louis A.: *Practical Proctology.* (Saunders, 1938), and Yeomans, Frank C.: *Proctology* (Appleton-Century, 1936) as well as Bacon, *op. cit.* Also see, Moorhead, John J., New York State Journal of Medicine, 38:1327 (October 15, 1938).
4. Bacon, Harry E.: *Anus, Rectum and Sigmoid Colon.* Lippincott, 1945.

him to the company physician, and it was diagnosed as an external thrombotic hemorrhoid. Suppositories were prescribed, and when he did not improve, he went to his family physician, who removed the hemorrhoid.

The patient was referred to me by the carrier for an opinion as to whether the condition was compensable. In my opinion, it was.

A number of other cases have been seen with varying rectal conditions, ascribed by the patients to their work, but none were as clear as these three. Some presented conditions, (like ischio-rectal abscess) that could not possibly be causally related to occupational effort.

COMMENT

The rectal conditions above mentioned might be classified in the group of diseases *usually* not produced by trauma, such as toxic goitre, urinary calculi (forming after vertebral fracture) or rupture of a gastric ulcer (following a forceful blow to the stomach). This contrasts with cases obviously a result of trauma, such as infection at the site of a burn, laceration or fracture. At the opposite pole are disorders which *never* result from trauma such as diphtheria, trichinosis or hemophilia.

I suggest criteria similar to those in the hernia section of the Workmen's Compensation Act which would do justice to both employer and employee in considering the compensability of rectal conditions:

(1) Acute onset while employed at work with one or more symptoms of pain, bleeding or protrusion.
(2) Immediate report to the employer.
(3) Examination within 24 hours by a physician.
(4) Demonstration of a rectal condition considered compensable.

Pre-employment physical examination should be more carefully performed to rule out the possibility of pre-existing disease of the rectum. Such conditions may exist in mild or more severe form prior to the onset of an acute episode at work. The Workmen's Compensation Act, however, is liberal and pays for aggravation as well as for direct cause. In the examination, the applicant should be told to strain as at stool, to determine whether there is a tendency for prolapse of the mucous membrane or hemorrhoids. A digital examination which shows a very relaxed sphincter, should be looked upon with suspicion.

40 Spruce Street

THREE-MONTH FETUS BREATHES AND SWALLOWS

Two Chicago doctors have demonstrated by means of a dye and x-rays that the important functions of breathing and swallowing develop as early as the 12th week in an unborn child.

Writing in *The Journal of the American Medical Association,* the authors—M. Edward Davis and Edith L. Potter from the Chicago Lying-in Hospital — state that these experiments were carried out on two groups of patients: one made up of 16 women, who had to have their pregnancy terminated in the first half of the period and the second consisted of 10 women who were delivered by a cesarean.

The dye was injected into the sac containing the fetus. From 17 to 52 hours later the pregnancy was terminated and the fetus was sent to the x-ray laboratory. The first group of fetuses showed the dye in all parts of the lungs, in the stomach and throughout the intestinal tract, demonstrating that the fetus aspirated the fluid within the sac and exhaled it. Thus there is evidence that the fluid normally moves in and out of the lungs.

The second series of patients, who were delivered by cesarean operation, were treated in the same manner. X-ray examination of the infants' lungs immediately after delivery showed evidence of the dye in five, probable presence in two and no definite evidence in three.

The authors point out that the "general pattern of respiratory activity is developed very early in fetal life." During this period the respiratory movements are intermittent, irregular and shallow. "At birth air is substituted for fluid, and respirations become deeper, regular and continuous, but the pattern remains the same. The major change involves the substitution of air for fluid as a medium of exchange."

In conclusion Davis and Potter state that "fetal swallowing and complete gastrointestinal activity has been demonstrated for the first time in a human fetus, 12 weeks old, weighing 39 grams."

HEADACHE — IMPRESSIONS OF AN OPHTHALMOLOGIST *

Frank D. Carroll, M.D., New York City

Most of us are presented, day after day, with patient after patient whose chief symptom is headache. It is a medical problem of tremendous importance. I say problem intentionally because I feel that many a patient with this symptom visits a series of specialists without relief. I became especially interested in this subject because first, it was the outstanding complaint of most people who consulted me and second, because I helped so few. Let us consider then what does cause most headaches, where does the ophthalmologist come into the scene, what is ocular headache, how can the ophthalmologist help the patient, how can he assist the general practitioner?

Most headaches occur during or after a period of tension or mental stress. Horton [1] states that 50 per cent of the headache cases seen at the Mayo clinic are classified as "tension headaches". During this trying period of war and postwar difficulties, where is the sane person, above the moron stage, who has not been under some emotional tension? By all means let us search diligently for some organic defect whose correction will relieve the cephalalgia. Occasionally we may fail to diagnose the organic pathology which is present, but let us also remember that one of the most important factors is "nervous tension". If, after all the examinations, that is the only probable cause, I would favor informing the patient that his headache is due to "nervous tension". This is easily understood; it does not dignify his complaint by a medical diagnosis which will only increase his worries; and further, it points directly to the treatment.

A careful examination by the general practitioner followed by consultation with any specialist whose services seem indicated by the history or physical findings is most important. If these are all negative the patient is much more willing to accept the indicated treatment. This means usually some adjustment in his way of life. Many patients can make their lives less strenuous with only a few suggestions. Others need outlined for them a sensible, day by day program or a complete emotional reeducation. A few cannot be reeducated and have therefore, in a sense, incurable headache.

What does this have to do with the practice of ophthalmology? It is possible for almost everybody to wear a pair of glasses. If he has a headache and consults his oculist, the latter has many factors to consider besides his ophthalmologic findings. All experienced physicians intuitively make a psychologic appraisal of the patient during the course of the history and examination. They were doing this for many years before they heard the term "psychosomatic medicine". This concept of psychosomatic medicine, however, while not a new idea, is of great importance in considering the person with headache. What is wrong with your patient physically? What is his emotional status? A favorable result may occur if either or both of these conditions can be improved.

Turning now to ocular headache—what is it, what causes it, what cures it? It may be defined simply as any pain or discomfort in the head which has its origin in the eye. This pain may be anywhere in the head, or back of the neck, but is most commonly around the eye. It usually is a dull bilateral ache that has some relation to use of the eyes. The most common causes are refractive errors, intraocular diseases, and imbalance of the extraocular muscles. The refractive errors which produce most headache are hyperopia and astigmatism. It is easy experimentally to produce these errors in human subjects by placing lenses in front of normal eyes [2] and finding out what symptoms result.

A pair of five diopter spherical concave lenses placed before emmetropic eyes causes aching around the eyes especially if reading is attempted. Similar results are obtained with

* From the Department of Ophthalmology, College of Physicians and Surgeons, Columbia University, and the Institute of Ophthalmology, Presbyterian Hospital. Read at Annual Meeting, The Medical Society of New Jersey, April 23, 1947.

cylindrical lenses. If oculists would stop using the term "eye strain" for such symptoms, many patients would be benefitted. It is ocular fatigue. Many a patient has developed an ocular neurosis worrying about this so called "eye strain". He conjures up a strange mental picture of his unfortunate "strained eyes having to work so hard". Let us tell him that "straining your eyes" is a figure of speech like "straining your ears" and that it is no more possible for him to strain his eyes that his ears. If the patient has only one good eye and worries about this eye having to do "all the work", as he says, I tell him everything goes in the eye, that eyes do not "work" any more than his ears "work"; or I mention that if he closed off one ear, the other ear would not have any added burden imposed on it. Such simple analogies tend to allay the usual misconceptions.

Myopic patients seldom get eye fatigue except when they are overcorrected. Occasionally, however, one who is accustomed to 20/20 vision and whose myopia has increased so that he gets only, say, 20/40 vision, has discomfort. This may be due to the frequent contraction of the orbicularis and corrugator muscles in squinting; or, more likely, it is the mental fatigue associated with trying to distinguish objects in a 20/40 visual world by one accustomed to a 20/20 world. A similar condition occurs when an automobile windshield becomes less transparent due to rain or snow. Then, the mental fatigue of driving long distances under such conditions is, of course, much greater than when looking through a clear windshield.

Ocular fatigue due to muscle imbalance may be produced experimentally by placing prisms before eyes with orthophoria. Investigations with the electromyograph indicate that "sustained contractions of the muscles of the scalp and neck are the cause of a major part of the headaches associated with extra ocular muscle defects".[2] Here again there are great differences in the ability of individuals to tolerate an imbalance. The Cornell Medical College group working with the electromyograph conclude "individuals subject to tension states and having some muscle imbalance or refractive error develop headaches of greater severity than do those individuals with the ocular defects alone".

Aniseikonia, or difference in size of the retinal images, probably accounts for some eye symptoms; at least there are occasional patients who insist their eyes were never comfortable until they wore the special lenses for aniseikonia.

The intraocular diseases which cause headaches are well known to you. Iritis and glaucoma are the most important. Every year most of us see cases of unilateral or even bilateral glaucoma which have been treated for "sinus headache". It is by keeping in mind the possibility of glaucoma in every adult patient that we recognize it in its earliest form.

For practical purposes let us consider the treatment of one every day problem. A mother brings in her child because he has headaches at the movies or, more likely, after the movies. She thinks that he needs glasses. Your examination shows no appreciable refractive error or muscle imbalance. Questioning may reveal that the child gets headaches after seeing basketball games or other athletic contests. I call these "excitement headaches"; they are a form of tension headache. In my opinion the best treatment is a firm statement to the mother stating, first, that the eyes are healthy and normal, that the headaches are not due to the eyes, and no glasses will be helpful; second, I say that such headaches are common and are probably due to excitement, and suggest fewer, or at least shorter, periods of attendance at perhaps less thrilling productions. One theory of the mechanism of these headaches is that they are due to vasodilation of cranial vessels. This hypothesis presupposes a vasoconstriction of these vessels during the excitement of the moving picture and then a compensatory vasodilation accompanied by headache. The other theory would attribute the pain to prolonged contraction of the muscles of the scalp and neck.

A different problem is presented with the unilateral headaches associated with ocular symptoms. Migraine and socalled histamine headache seem to be two distinctly different en-

tities and I shall review the different diagnostic points. Migraine tends to occur in a younger age group; in about ten per cent of patients, the attack begins with visual phenomena which include scotomas, flashes of light, or hemianopsias; these are never present in histamine headache. In migraine, the visual symptoms are followed by headaches and frequently by nausea and vomiting. In the histamine type the patient is frequently awakened at four or five o'clock in the morning by an excruciating unilateral pain, often over or around one eye; this eye shows marked lacrimation; on this side the nose is blocked and the skin of the face is red and warm. Epinephrine stops the histamine headache rapidly. Ergotamine tartate or, probably better, the new DHE45 (dihydroergotamine)[3] relieves the headache of most migraine patients if given at the onset of the attack.[4]

A typical histamine headache can be reproduced in a person subject to these headaches by giving histamine parenterally. I have recognized only ten instances of this type of headache in my eye practice during the past seven years. All of them were cured or greatly improved by treating with gradually increasing doses of histamine subcutaneously. One recurred but promptly responded to another course of histamine.

The mechanism involved in the production of a migraine attack is most interesting. The visual phenomena are probably associated with a vasoconstriction of the intracranial vessels and the headache with a vasodilatation of cranial vessels especially branches of the external carotid. Experiments tend to indicate[5] that the visual scotomas may be abolished temporarily by giving a vasodilator such as amyl nitrite in dosage sufficient to produce vasodilation but not enough to cause a fall in blood pressure. As soon as the transitory effect of the amyl nitrite wears off, the scotomas reappear so that it is of no therapeutic value. For the headaches, vasoconstricting agents which reduce the amplitude of pulsation of the cranial arteries (such as ergotamine tartrate) are of great value.

The relation of allergy to migraine is not clear but certainly some headaches are on an allergic basis. If a patient is sensitive to a food such as chocolate, milk, fish or pork, the elimination of the food is sometimes of great value. We have several proved cases of retrobulbar neuritis due to food allergies. In this respect I have often wondered why it is that headache often precedes retrobulbar neuritis for several days or longer. The headache is usually described as over or around the involved eye and occurs in patients who have no detectable nasal or paranasal disease.

The oculist viewing the discs and taking his fields is often the first to suspect an intracranial expanding lesion. Headache due to tumor is thought to be caused by traction on pain sensitive intracranial vessels and venous sinuses or direct pressure on nerves containing afferent fibers for pain, namely, the fifth, ninth and tenth cranial nerves, and the first two cervical nerves. Also, the oculist, examining the fundus, may be the first to suspect vascular hypertension. In these cases, headache is said to arise from the distention and amplitude of the pulsations of the cranial vessels.

I shall avoid discussing headache due to nasal and paranasal conditions except to say that lesions located anywhere in the area supplied by the ophthalmic nerve and sometimes by the other branches of the fifth nerve may cause referred pain in and especially around the eye. Charlin[7] has described a syndrome which has received much attention in the foreign literature. This consists of unilateral rhinorrhea accompanied by severe ocular pain and lacrimation. Keratitis or corneal ulceration may be present. Simple cocainization of the anterior ethmoid region which is inflamed on the side of the involved eye is said to result in prompt cure. Castroviejo[8] tells me that he has observed a few such cases.

In summary, I have reviewed some of the common causes of headache in patients who consult the ophthalmologist. Many of these individuals are referred to us, and we have to refer many to other colleagues. The more thorough our knowledge of this problem, the better we serve our patients. A psychogenic headache may be much more severe than one

due to a brain tumor. We know the importance of evaluating the whole individual as well as of determining his refractive error. We have spoken of excitement headaches where all the physical and laboratory examinations were negative. We have learned much in the past decade regarding the mechanism of different headaches. Let us continue to learn much more about the treatment of these physical conditions and emotional states which singly or together produce the nation's most common symptom—headache.

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635 West 165 Street

INDUSTRIAL REHABILITATION

A British industrial psychiatrist describes the successful work of England's first industrial Rehabilitation Center, which treats patients suffering from occupational and social maladjustment.

Thomas Ling, M.D., Medical Director of Roffey Park Rehabilitation Center, says that "during one 12-month period 580 men and 460 women have been treated with satisfactory results. Many of the cases were medically and psychiatrically difficult and a minority were complicated by insoluble social problems. The greater number were suffering from occupational and social maladjustments."

Rehabilitation should be a part of medical therapy of all illnesses. The better and earlier the treatment, the fewer will be the cases of permanent disability which will require vocational training and the more satisfactory the results in those so trained.

Roffey Park operates in the following way:

"The Center provides residential facilities for 110 patients of both sexes between the ages of 18 and 50 years. Priority of admission is given to employees of subscribing firms although admission is not limited to patients from such sources.

"Each patient is given a thorough examination and psychiatric interview, together with appropriate intelligence and aptitude tests. The patient is interviewed by the social worker who has had wide industrial experience.

"Emphasis is placed on the treatment of each case with physical, occupational and psychologic features receiving due attention. Occupations for men consist of engineering workshops, woodwork, wood-sawing and gardening. Women's occupations consist of domestic work, needlework classes, gardening, art classes, assisting in the nursery (established on the premises for children of the staff) and training in elementary dietetics. Unless there are medical contraindications, each patient carries out a daily graded course of physical training.

"Three resident psychiatrists and visiting specialists are available. Patients are seen by the doctor at least twice a week and more often if necessary. Problems in the patient's life are discussed and help is given toward eradicating them. In some instances difficulties have arisen at work, in others at home. In others the problems may be of a more deep-seated nature. A full understanding of the patient's working background is essential, and close contact is kept with the office or factory from which the patient has been sent.

"Each evening a communal activity, including discussion groups, gramophone recitals, amateur theatricals, motion picture shows and dances, is arranged for the patients.

"Patients remain for an average period of six weeks. Before discharge careful attention is given to subsequent placement at work. The majority of the patients are able to return to their normal employment, but some present a problem in placement. To help in this work, Britain's Ministry of Labor officials visit the Center each week."

The author emphasizes the fact that Roffey Park has proved a success since its establishment in 1943. A sum of $300,000 was subscribed from industry at that time and a large country house, 30 miles from London, was purchased. It is maintained by a number of leading employers in the country. Dr. Ling hopes that "industry will sponsor additional centers in the future and, ideally, there should be at least one such hospital outside each big city, linked up with the main industries of the district."—(Abstracted from *Hygeia.*)

STATE ACTIVITIES

TRUSTEES MEETING

A special meeting of the Board of Trustees was held November 16, 1947, in Trenton.

Present were: Dr. Crowe, Chairman, who presided; Dr. Green, Dr. Schaaf, Dr. Hornberger, Dr. Sica, Dr. Johnsen, Dr. Lance, Dr. Hawkes, Dr. Dodd, Dr. Fithian, Dr. Wood, Dr. Coleman and Dr. Allman. Also present were: Dr. Davidson, Dr. Scott, Dr. Barkhorn, Mr. Bryan and Mrs. Madden.

REPORT OF THE PRESIDENT

Dr. Schaaf presented the following resolutions, approved at the special meeting of the Medical Practice Committee on November 9, which meeting was called by the president for discussion and advice prior to bringing these matters before the Board for consideration:

A. Cerebral Palsy and Other Clinics

Whereas, there is a growing tendency on the part of public or private agencies to establish clinics or systems of medical service which do not conform to the legal requirements of the Medical Practice Act of the State of New Jersey; and

Whereas, such procedure does not properly serve the best interests and welfare of the people of New Jersey; and

Whereas, it is in the best interests of the public that medical service, insofar as possible, be concentrated in existing community hospitals under the communty medical profession;

Be it therefore resolved, that The Medical Society of New Jersey disapprove the establishment or conduct of all clinics not directly under the immediate supervision of a licensed physician or surgeon who is qualified by training and experience properly to conduct such clinics, or without a medical attending staff adequate in number to meet the needs; and

Be it further resolved, that wherever possible existing facilities be utilized and expanded, if necessary, to meet the needs; and

Be it further resolved, that all public and private agencies concerned with medical care be advised of this resolution.

Upon motion by Dr. Schaaf, seconded by Dr. Allman and unanimously carried, the above resolution was approved.

B. Subsidizing Nurses Training Schools and Payment by the State for Hospital Care of the Indigent

Whereas, the health and welfare of the people of New Jersey require the expansion of facilities for the undergraduate training of nurses, and for the payment of hospital cost for hospital care of persons in the low income group, and for an expanded program for the care and treatment of wards of the State;

Be it resolved, that The Medical Society of New Jersey invites the attention of the Governor and the Legislature to the need of additional state revenue for the following specific purposes:

1. To subsidize nurses training schools throughout the state of New Jersey under the general direction of Rutgers University.
2. To assist the communities of the state in defraying the cost of hospital care for indigent and medically indigent persons in voluntary hospitals.
3. For an expanded program for the care and treatment of wards of the state, the care and treatment of whom is the responsibility of the State Department of Institutions and Agencies.

Dr. Schaaf informed the Board that the purpose of the resolution has the endorsement of representatives of both the New Jersey Hospital Association and the New Jersey Nurses' Association and moved the adoption of this resolution. Motion was seconded by Dr. Sica and unanimously carried.

Manual of Standards for Private Hospitals in New Jersey

Dr. Schaaf reported on the Manual of Standards for Private Hospitals in New Jersey as forwarded to The Medical Society of New Jersey by the State Department of Institutions and Agencies for review and approval. After conference with representatives of the State Department of Institutions and Agencies, the following four points still remain to be coordinated, and should be reiterated to the Hospital Licensing Board by the Board of Trustees of The Medical Society of New Jersey:

1. That the Manual of Standards for Private Hospitals in New Jersey should in general relate only to hospital care for patients, since the provision of medical service is legally the function of physicians licensed by the State Board of Medical Examiners.

2. That we emphatically support the principle that no practitioners holding any other than a full license to practice medicine and surgery should be permitted to practice as a staff member of a hospital.

3. That we again propose the outline of "By-Laws of the Medical Staff" which has been ap-

proved by both The Medical Society of New Jersey and the New Jersey Hospital Association as a recognized guide for hospital staff organization.

4. That we urge as a principle that all statements contained in the Manual of Standards relative to medical staff organization should be suggestive and not mandatory since these are almost exclusively professional matters in regard to which standards have already been established by recognized national professional bodies.

Upon motion, seconded and carried the president was authorized to give the approval of the Society to this Manual, after all remaining points of difference have been reconciled.

FALL CLINICAL CONFERENCE

The Board congratulated and extended a vote of thanks to the Passaic County Medical Society, and in particular, Dr. Sigurd W. Johnsen for his individual effort and management, on the success of the recent Clinical Conference in Paterson. Motion was seconded and carried unanimously.

NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

The National Foundation for Infantile Paralysis requests The Medical Society of New Jersey to set up an advisory committee to work with that organization, naming Dr. Harrold A. Murray, Dr. Leopold Szerlip, Dr. Harold W. Smith and Mr. James E. Bryan as members of the committee.

Dr. Fithian moved that President Schaaf be empowered to appoint such a committee. Seconded by Dr. Lance and unanimously carried.

AMERICAN HEART ASSOCIATION—NEW JERSEY CHAPTER

The proposal of the American Heart Association to establish a New Jersey Chapter, was endorsed upon motion by Dr. Schaaf, seconded and unanimously carried.

TUMOR CLINIC

The opinion of the Board was requested on the establishment of a tumor clinic offering x-ray and clinical laboratory services to physicians in the area. A single fee for complete examination would be charged, and split to cover x-ray, laboratory service and physical examination.

It was the unanimous opinion of the Board that the establishment of such a clinic be declared unethical in that it does not conform to the established ethical principles of the medical profession.

VETERANS' AGREEMENT AND LIAISON OFFICER

The Board reaffirmed its action of September 28, granting power to Medical Service Administration and the Veterans Liaison Committee in the signing of the new contract with Veterans Administration.

Upon motion, seconded and unanimously carried, the president was authorized to sign agreement No. 2 with Veterans Administration, this agreement to abandon the Liaison officer arrangement, with the provision that, if after six months it is found such arrangement is not satisfactory, appointment of such an officer will be reconsidered.

LABOR ADVISORY COMMITTEE ON WORKMEN'S COMPENSATION

Pursuant to a request made by Mr. Harper, Commissioner, State Department of Labor, for the nomination of two members of the Society to serve as members of the Commissioner of Labor's Committee on Workmen's Compensation, Dr. Sica moved that Dr. William K. Harryman and Dr. Marcus H. Greifinger, presently serving as members of the committee, be re-appointed. Motion seconded and unanimously carried.

A.M.A. HOUSE OF DELEGATES—ATTENDANCE BY DR. QUIGLEY AS OBSERVER

Upon request the Committee on Legislation was authorized to send Dr. Quigley to the A.M.A. House of Delegates as observer, provided his expenses are kept within the limits of the present budget of this Committee.

SUPPLEMENTARY BUDGET ALLOTMENT—WOMAN'S AUXILIARY

Upon motion by Dr. Schaaf seconded and unanimously carried, it was directed that in the expenditure of the special fund of $1,000 granted to the Woman's Auxiliary for public relations, disbursements from the fund shall be approved by the Advisory Committee to the Woman's Auxiliary, after conference with the Executive Officer and Executive Assistant.

RECONSIDERATION OF RECOMMENDATIONS TABLED AT MEETING OF SEPTEMBER 28, 1947

1. *Membership in the New Jersey State Chamber of Commerce*

Dr. Schaaf moved The Medical Society of New Jersey join the New Jersey State Chamber of Commerce for the ensuing year of 1948 if, after consultation with counsel, we find our tax-exempt position is not affected. Seconded by Dr. Sica and unanimously carried.

2. *Definition of a Public Health Center*

The following revised definition of a Public Health Center was presented and Dr. Schaaf moved its approval; seconded by Dr. Fithian and unanimously carried.

The Department of Health of New Jersey, in accordance with the provisions of the Hospital Survey and Construction Act (Public Law 725—79th Congress), defines (1) a Public Health Center and its functions, and (2) an Auxiliary Health Center and its functions, as follows:

(1) A Public Health Center is a publicly owned or controlled building or part thereof providing office quarters for the official health unit supplying public health services for a prescribed area having at least 25,000 population.

The functions of a Public Health Center shall be to provide facilities for carrying on the generally recognized public health services, and for demonstrating and applying disease preventive measures.

Facilities may be provided for such additional health services as are sponsored by the community in cooperation with the County Medical Society in which the Public Health Center is located, or in cooperation with The Medical Society of New Jersey.

(2) Auxiliary Health Centers may be located within the area prescribed for a Public Health Center; and shall operate as supplemental to and under the auspices of such Center.

An Auxiliary Health Center shall furnish to a limited degree such services as are provided by a Public Health Center.

CHRISTMAS GRATUITIES

Upon motion, seconded and unanimously carried, the usual Christmas gratuities were authorized.

Upon motion by Dr. Schaaf, seconded and unanimously carried, the meeting was adjourned at 3:30 p. m.

DAVID W. GREEN, M.D.,
Secretary.

LET'S BUILD A LIGHT-HOUSE IN NEW JERSEY!

The child who awakens in the dark is a frightened and appealing little figure. How about the child who must live always in the dark—the blind youngster? Most of the merriment and fun which is the birthright of every child is denied to him. We sympathize, of course, but there is something more we can do. In fact a group of public-spirited citizens has started a campaign to establish a camp for blind children. They have the site already—67 acres in Morris County; and they have plans whereby these children can get wholesome food, fresh air, athletic training, specialized instruction, experience in team work and in group living. No installation in New Jersey offers anything like this. The only thing needed to convert this into a reality is money.

Dr. Schaaf has asked me to serve as chairman of a committee to solicit funds for this camp. I'm not much good at money-raising, perhaps; but it seems to me that any one with a heart will respond to this appeal. And no appeal will draw funds from the man without a heart. This isn't an annual solicitation. It's a once-for-all donation, since the funds are needed to get the camp going. And I can assure you that every dollar contributed will go to the camp.

Blind children really need an opportunity like this—a chance to mature into self-confident, self-reliant citizens, integrated into the community at large. They can't get this opportunity themselves. We have to help them. Are you with us?

Send the check to me, c/o The Medical Society of New Jersey, 315 West State Street, Trenton 8. And make it payable to *New Jersey Camp for Blind Children, Inc.*

You won't get any medals and you won't get your name in the paper for contributing. But you will get something a little more heart-warming and valuable.

HARROLD A. MURRAY, M.D.

VISCO-RAY-OPAKE IS NOT OILY

Dr. Daniel B. Roth, author of *Examination of the Sterile Couple* an article which appeared in the October JOURNAL, 44:407, wishes to make the following amendment to a paragraph in that paper. The paragraph in question read as follows:

"Salpingography is done by the use of contrast solutions such as lipiodal, visco-ray-opake, and iodochloral. However, these oils are irritating and they are said to cause occlusion in partly obstructed tubes."

The implication of the above is that visco-ray-opake is an oily substance, whereas actually it is an aqueous medium which Hoffmann-LaRoche, Inc., developed specifically to obviate the possibility of occluding partly closed tubes. In fairness to them this brief clarification is published.

SUPPLEMENTARY LIST OF MEMBERS No. 5 TO THE OFFICIAL LIST

Ambrose, Robert R., 304 E. High st., Bd. Brook (18)
Delatush, George A., 211 Park st., Montclair (7)
Falcone, Nicholas A., 68 Watchung av., North Plainfield (18)
Falkinburg, LeRoy W., Collingswood (15)
Foley, James G., Basking Ridge (14)
Hallett, Frederick S., 200 Passaic st., Hackensack(2)
Haut, E. Milton, 21 Main st., Farmingdale (13)
Inge, Hutchins F., 205 S. Orange av., Newark (7)
Kahrs-Dreyfors, Madeline T., N. J. State Hospital, Marlboro (13)
Klosterman, Julius A., River Road, Bogota (2)
Klostermyer, Louis L., Mountainside Hospital, Montclair (7)
Kralik, Joseph J., 555 Market st., Newark (7)
Kyhos, Emma D., Roche Park, Nutley (7)
Lewin, Leo, Howard Blvd., Mt. Arlington (14)
Mazzei, Armand S., 282 Liberty st., Long Branch(13)
McCarthy, Cornelius P., 887 Blvd., Bayonne (9)
Muller, Joseph H., 867 S. 13th st., Newark (7)
Neville, Robert J., 547 Main st., Hackensack (2)
Pyle, Louis A., 89 Fairview av., Jersey City (9)
Rosiello, Louis E., 712 Wood st., Vineland (6)
Sandler, Samuel A., Laurelton Parkway, Teaneck(2)
Schurman, Emil W., 779 Bergen av., Jersey City (9)
Schwartz, Leon J., 88 Park av., Rutherford (6)
Severud, Olaf J., 205 North av., Bogota (2)
Snyder, Howard P., Box 6, Fanwood (18)
Sullivan, James A., 19 Kensington av., Jer. City (9)
Taylor, Earl S., 2 Elm Road, Princeton (11)
Urban, Lawrence J., 679 Avenue C, Bayonne (9)
Van Riper, William D., 441 W. Englewood av., West Englewood (2)
Willis, Benedict P., 185 Montross av., Rutherford (2)
Zacchino, Arnold, 1001 Anderson av., Palisade (2)

ASSOCIATE MEMBERS

Bombardieri, Anthony R., 251 Centre st., Nutley (7)
Brown, Frank J., 326 Richmond av., P. Pleasant(15)
Davis, John F., 10 Washington st., Bloomfield (7)
Greco, Roger A., 249 N. 15th st., Bloomfield (7)
Harris, Leonard, 89 Lincoln Park, Newark (7)
Jaffe, Gorman, 626 6th st., Lakewood (15)
Kollmar, Robert, 20 Great Oak dr., Short Hills (7)
Piegari, Felix H., 111 Mt. Pleasant av., Newark (7)
Schaefer, Kenneth F., 763 Broad st., Newark (7)
Statman, Bernhardt J., 849 S. 12th st., Newark (7)

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Chairman Nutrition Committee

1. *Is it better to give Vitamin C during pregnancy or during lactation?*

   The tissues require a greater concentration of ascorbic acid during pregnancy.

2. *Do amino acids control the appetite?*

   Protein preparations (whether in the form of hydrolysates or mixtures of amino acids) do not inhibit the appetite.

3. *Are vitamins indicated in heart disease?*

   Vitamin E in large doses (200 to 600 milligrams of ephymal) has a marked effect upon patients with congestive heart disease and with anginal syndrome. The effect of vitamin E upon coronary pain is attributed either to direct action on the coronary vessels (by dilation of the capillaries) or to some action on the metabolism of the heart muscle.

4. *What can be done to prevent large nitrogen losses in surgical patients?*

   Attempts should be made to induce a large enough positive balance by preoperative feeding. This must be done vigorously in patients who can take food by mouth before operation for a period of five days. Three meals a day with additional protein supplied as hydrolysates of casein or lactalbumin at intervals while the patient is awake. Give the preoperative patient a diet containing three times the nitrogen which would be required to produce postoperative equilibrium.

5. *I have a patient who has had cheilosis in the corners of the mouth for about a year. She also has a gastric ulcer. I have given her riboflavin without any results. Will any other medication help clear up the cheilosis?*

   Riboflavin is the indicated remedy. However oral administration may be ineffective in the presence of a digestive disturbance. Implantation of pellets containing riboflavin and cholesterol subcutaneously in the patient's thigh will aid resorption for several months. Pellets of 12 milligrams of riboflavin may be inserted each month.

6. *If protein is so essential for growth, then isn't it true that ham and eggs should be a good breakfast dish?*

The protein in ham contains insufficient cystine and methionine for optimum growth. But when this is supplemented with these amino acids, then the growth promoting factors are good. These amino acids are found in egg white protein. Ham alone is not sufficient to help promote growth. Eggs alone are sufficient, and ham and eggs together do the trick and make a palatable dish.

7. *Many patients with low basal metabolic determinations also have low hemoglobin levels. If these patients are given thyroid extract (to elevate the metabolic reading) will the anemia be relieved?*

The hemoglobin will not return to normal in proportion to the rate of return of the metabolism. Liver contains an antithyrotoxic factor and should not be used when an effort is being made to elevate the metabolism. Wait until the thyroid activity is normal before treating the anemia with liver. The anemia will not be relieved by thyroid extract.

HIGHER GRADE FOR NATIONAL GUARD DOCTORS

Officials of the New Jersey National Guard announce a recent change in memoranda submitted by the National Guard Bureau in Washington. The pertinent paragraph is:

"Vacancies for medical officers in the National Guard may be filled by assignment thereto of qualified individuals who are one grade higher than that specified by applicable Table of Organization."

This means that where a regimental surgeon is normally in the grade of major, under this ruling he may be a lieutenant colonel.

There are some restrictions, chief one being that the medical officer must have held the grade while on active duty or have the grade in the Organized Reserve.

OBITUARIES

DR. HENRY B. DIVERTY

On November 13, 1947, death came to the dean of South Jersey practitioners, Dr. Henry B. Diverty, a man who was born when Abraham Lincoln was still alive, who practiced actively in our state for sixty years. Dr. Diverty came from a family with a long tradition of service to the state. He was graduated in 1887 from the Jefferson Medical College and opened his office in Woodbury that year. From 1924 to 1939 he was a member of the State Board of Medical Examiners. For two decades he served the Woodbury Board of Health, usually as its president. For thirty years he was medical examiner for the public schools. He probably established something of a record by serving for half a century as an examiner for the Prudential Life Insurance Company. And for the last fifty years he was a familiar and beloved figure at the Annual Meetings of The Medical Society of New Jersey.

DR. CLARENCE B. DONGES

Dr. Clarence B. Donges, a general practitioner in Camden for 57 years, died in Cooper Hospital on October 6, 1947.

Dr. Donges was born in Donaldson, Pa., in 1869, and was graduated from Jefferson Medical College in 1891. He served his internship at the University of Pennsylvania Hospital before establishing offices in Camden. He was active in examination and treatment of veterans of both World Wars.

DR. ISRAEL FEIGENOFF

Dr. Israel Feigenoff, former chief pediatrician of Barnert Memorial Hospital in Paterson, died at the age of 70, on October 5, 1947, after a long illness.

Born in Russia in 1878, Dr. Feigenoff came to this country in his youth. He received his medical degree from Long Island Medical College in 1905, and practiced in Brooklyn for a year before moving to Paterson. He was on the staff of Barnert Memorial Hospital 30 years, and at the time of his death was a physician in the public school system.

DR. HYMAN M. GLASSTON

Dr. Hyman M. Glasston, a prominent Linden physician, died suddenly on October 19, 1947.

Dr. Glasston was born April 23, 1900, in Burlington, Vt. He was graduated from the University of Vermont Medical School in 1924 and served his internship in St. Elizabeth Hospital, Elizabeth.

Dr. Glasston served the City of Linden in various capacities, as city physician, physician to the Board of Health, Board of Education and Fire Department. He was a prominent figure in many civic, charitable and religious activities in the city. He was a past president of the Clinical Society of the Elizabeth General Hospital, and a member of the staffs of the St. Elizabeth and Elizabeth General Hospitals in Elizabeth.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

BRUCELLOSIS

While brucellosis has long been recognized as an infectious disease causing losses among animals, its significance in relation to human health is of recent development. During the past two decades the transmissibility of brucella infection from animal to human hosts has been firmly established. The consequences of human brucellosis are viewed with increasing alarm by the medical profession.

Although a brucellosis (human—undulant fever) patient discharges the etiologic agent in the urine and other excretions, direct infection from man to man seldom occurs. Hence, the fundamental method of prevention among humans is control of the disease among animals.

There are three types of microorganisms capable of causing this disease in man. The varieties of brucella currently recognized and their natural hosts are: *Brucella melitensis* of goats, *Brucella suis* of swine and *Brucella abortus* of cattle. Cases occurring singly (in a family or community) usually harbor *Brucella abortus;* whereas, epidemic outbreaks of undulant fever result from *Brucella suis* infection.

Susceptibility of host species may be outlined as follows:

Species	*Primary Host*	*Secondary Hosts*
Brucella abortus	cattle	(man) (horse)
Brucella suis	swine	(man) (cattle)
Brucella melitensis	goats (sheep)	(man) (cattle) (swine)

The pathogenicity of *Brucella suis* and *melitensis* to humans is not perceptibly reduced by passage through cattle. Hence, undulant fever traceable to raw milk and milk products may assume the same degree of severity as if it were transmitted directly from the primary host species. The virulent strains of *Brucella suis* and *Brucella melitensis* may occur in areas in which goat raising and swine raising are not well developed industries. Under such circumstances, when highly pathogenic varieties of brucellosis are transmitted by cattle the infection must have been previously acquired by association with infected swine and goats. Epidemiologic studies (which form the basis of rational treatment) depend to a large extent upon positive identification by laboratory procedure of the species involved in each case of brucella infection.

The disease is found in two groups of citizens; those who handle infected animals and their products, and those that become infected by the consumption of food contaminated with brucella microorganisms. The handlers include packing house workers, laboratorians, dairy plant workers, veterinarians and livestock dealers, whose occupations expose them to frequent mass brucella infection. However, brucellosis is classified as a milk borne disease of great importance, for which pasteurization of milk and milk products affords a substantial safeguard against the disease. About five thousand cases of brucellosis occur annually in this country, according to reports. The actual incidence is certainly much higher.

During the period from 1941 to 1945, inclusive, the average number of cases of human brucellosis in New Jersey was 66. The results of the cases reported and investigated by agents of the State Department of Health or local health officials are shown in the table.

The reported attack rate in New Jersey of 1.5 per 100,000 remained fairly uniform throughout recent years. Raw milk is the predominating source of infection, but the occurrence of the disease among occupational groups emphasizes the danger of acquiring brucellosis through channels other than the digestive tract.

Regardless of the vague symptoms, these forms of brucellosis are usually recognized: ambulatory, mild, undulatory, intermittent and malignant. The patient may suffer fever, sweating, temporary "arthritis" and severe body pain. Usually, after three to five repeated abatements and recurrences of the symptoms, the patient recovers completely, or the disease becomes chronic and endures for years. Some patients are said to be dismissed as neurasthenics. Since a diagnosis by clinical manifestation is seldom reached, specimens of the patient's blood should be taken and sent to a properly equipped laboratory for positive identification.

UNDULANT FEVER

Total cases reported and investigated by New Jersey (state and local) Health Officials during the period — 1941-1945.

Year	Total No. Cases	Mortality	Raw milk exclusively	Raw & past. milk	Preponderance past. milk	No date	Past. milk exclusively	OCCUPATIONAL: Butcher & meat inspec.	Dairy man	Milk plant wkr.	Lab. worker	Veterinarians
1941	76	2	44	12	5	2	13	3	1	0	0	1
1942	61	0	32	12	4	1	11	1	0	0	1	0
1943	47	0	27	11	3	1	5	0	0	0	0	0
1944	71	0	35	16	6	3	11	1	11	0	0	1
1945	73	0	37	9	5	2	21	1	7	2	1	2
Total	328	2	175	60	23	9	61	6	19	2	2	4
5-year average	65.6	.4	35	12	4.6	1.8	10.5	1.2	3.8	.4	.4	.8

BOOK REVIEWS

Diseases of the Chest, with Emphasis on X-ray Diagnosis. By Eli H. Rubin, M.D., F.A.C.P., F.C.C.P. With a section on The Principles of Surgical Treatment, by Morris Rubin, M.D. Pp. 685 with 355 illus. and 24 plates in color. Phila. and London, W. B. Saunders Co., 1947. $12.

This excellent book is a concise and logical survey of chest diseases, and fulfills the intentions of the author who designed it "for use by general practitioners, sanatorium physicians, medical students and radiologists". It is well written, in pleasing format, and superbly illustrated by reproductions of roentgenograms which well illustrate the subject matter under discussion. The material is documented by case reports from the extensive clinical experience of the author. Of aid to those who are interested in amplifying their knowledge by referring to original sources, a comprehensive bibliography follows each chapter, arranged under subject headings.

Sections on tuberculosis, diseases of the lungs and bronchi, diseases of mediastinum, diaphragm and pleura are well arranged and thoroughly covered. There is a good chapter on heart-lung disease, which would not have suffered from amplification. The section on principles of surgical treatment is compact, and wisely concerns itself only with fundamentals. One cannot quarrel with the omission of certain refinements in technic, such as the muscle split thorocoplasty, or Overholt's prone position for resection of tuberculous lobes, though these should have been mentioned.

Pneumoperitoneum as a method of treatment of pulmonary tuberculosis is dismissed without adequate discussion. The opinion of the author, though justified by his personal experience, (and to a certain extent shared by the reviewer), should not condemn the procedure without referring the reader to the numerous favorable reports in the recent literature.

On the whole, however, the author is eminently fair, and his comprehensive survey is well worth reading. It is a valuable reference work for the general practitioner and radiologist and a good text for the medical student.

OTTO S. BAUM, M.D.

Gynecology; With a Section on Female Urology. By Lawrence R. Wharton, Ph.B., M.D. 2nd ed. Pp. 1027 with 479 illustrations. Saunders Co., Philadelphia, 1947. $10.

With so many good texts on gynecology now available, the physician asks himself whether this book, in addition to his previous accessions, is really necessary for his practice of gynecology.

The 236-page section on female urology alone would make this a worthwhile addition to the library of any gynecologist, urologist or general practitioner. This differs from other gynecologic texts in the practical detail in which the author discusses the milder as well as the more serious urologic complaints. He has done a much needed job in correlating modern physiologic concepts of both the urinary and genital tracts, and the way treatment is conducted in actual practice. This approach should prevent some needless or, at least, unsatisfactory operations, and give the practitioner many grateful patients.

Endocrinology and chemotherapy are thoroughly covered in a "down to earth" objective manner, carefully evaluating established facts.

The book is well-written, in simple language, from the standpoint of a conscientious teacher. The author distinguishes between fact and personal opinion, discusses unsettled problems and stresses fundamental principles. At the beginning of each chapter there is an outline; at a glance, the subject may be seen in its proper proportions. This is a valuable contribution by an eminent gynecologist, and should prove highly useful to all who read it.

A. O. GODFREY, M.D.

Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1946. Cloth. $1.00. pp. 135, Chicago: American Medical Association, 1947.

This volume was formerly of most interest to those who wished to know why the Council on Pharmacy and Chemistry had refused to accept certain preparations. The reports were mainly those of rejection; though, through the years, the educational nature of the Council's work was attested by status reports on drugs, or therapeutic procedures, or preliminary reports on agents showing promise or usefulness but not yet ready for adoption by the profession. In recent years, the tendency has been toward a preponderance of the educational type of report. In the present volume, both phases of the Council's work are represented.

Three reports are of vigorous condemnation: first, the report on Cabasil, a curiously unscientific mixture whose exploitation for use in a multitude of diseases is aptly summarized by the subtitle of the report, "Quackery Unlimited"; second, the report on the pseudo-scientific Ethylene Disulphonate (Allergosil brand), a preparation of highly uncertain nature exploited for use in allergic conditions; third, Formula A-N-1, a report of an expensive but poor substitute for aspirin and citrate of magnesia, promoted to industrial concerns for use in reducing absenteeism due to colds.

Among the status reports, the excellent article by Dr. Samuel M. Feinberg, "Histamine and Antihistaminic Agents", is probably most worthy of mention. Since its appearance, the Council has accepted for inclusion in *New and Nonofficial Remedies*, the two new agents of this class evaluated in the article benadryl hydrochloride and pyribenzamine hydrochloride.

Medical investigators will be interested in the informative report on the Council's new Therapeutic Trials Committee. The statement on the revised rules of the Council is of concern to all who are interested in progressive rational therapeutics.

All in all, the book represents superb value for a single dollar.

New and Nonofficial Remedies, 1947. American Medical Association. $3.00. pp. 749. Philadelphia: J. B. Lippincott Co., 1947.

The new edition of *New and Nonofficial Remedies* is now published by J. B. Lippincott and Company, though it is still issued under the supervision of the Council on Pharmacy and Chemistry. One innovation is the relegation of tests and standards to the back of the book, which makes the text more convenient for the physician, for whom it is primarily intended.

There appears to be no extensive revision in the general articles or chapter head discussions, although several new monographs have made their appearance and others have been revised. A new chapter, "Unclassified Therapeutic Agents", includes monographs on gold compounds and iodine compounds for systemic use. This is in line with the policy adopted some years ago of classifying accepted preparations according to pharmacologic action and therapeutic use.

Descriptions of thirteen new preparations appear in this volume. This excludes, of course, new brands or dosages of already accepted agents. Among the new preparations are the vaccines representing combinations of pertussis with diphtheria and tetanus organisms; the new histamine-antagonizing agent, benadryl hydrochloride elixir; furacin (nitrofurazone) a new topical anti-infective agent; streptomycin; heparin sodium; parenamine, a new casein hydrolysate; thiouracil; naphuride sodium (suramin sodium) a new trypanocide; and tuamine, a new vasoconstrictor. One notes the increasing appearance of generic designations in conformance with the revised Council's rules on acceptance of agents bearing protected or trademarked names.

New and Nonofficial Remedies remains a valuable authoritative compendium of modern rational therapeutics.

Allergy in Practice. By Samuel M. Feinberg, M.D., with the collaboration of Oren C. Durham, Chief Botanist, Abbott Laboratories, and Carl A. Dragstedt, Ph.D., M.D. 2nd rev. ed. Pp. 838. Illustrated. Chicago, Year Book Publishers, Inc., 1946. $10.50.

The student of allergy who is interested in a comprehensive survey in which the basic body of knowledge concerning this subject is presented in a practical manner, will find this a useful book of reference and study.

Immunologic concepts and theories are presented in brief. Allergens are discussed in detail as to their incidence and allergenicity and, as might be expected from this author, the chapter on allergy to fungi is particularly cogent. Details of the ideas and technics employed in working with molds, are interestingly recorded as well as their geographic and seasonal incidence. For the specialist who wishes a summary of the knowledge concerning fungus allergy this chapter is highly recommended.

The specific treatment of allergies is often a rather simple task, while non-specific management may take the allergist into many other branches of medicine such as otolaryngology, endocrinology, psychiatry, etc. Non-specific fields of therapy are adequately presented and discussed and form an excellent starting point as a guide to further study in these fields which are of much importance in the care of the large number of non-specifically allergic individuals.

An authoritative chapter by the botanist, Oren C. Dunham, describes the distribution of pollens by seasons and states. Specific pollen therapy is presented in detail and will be of value to many who are not sufficiently familiar with dosages, intervals of treatment, and other such technical points.

Two chapters on histamine and histamine antagonists brings the text up to date with the current literature of 1946.

Dr. Feinberg has presented us with a clear and readable text of a practical nature which will be of interest to the specialist and of value to any non-specialist who wishes to understand more about this widespread affliction.

Louise Fischer, M.D.

COUNTY SOCIETY REPORTS

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* held at Bergen Pines Hospital, Oradell, N. J., on the evening of October 14, 1947, was called to order by the President, DR. RUDOLPH C. SCHRETZMANN, at 9:08 p. m.

The proposed Bergen County Hospital was discussed and a motion was made that the report of the survey made in an attempt to ascertain the Bergen County physicians' opinion on this project be published in the Bulletin.

Dr. Littwin, Chairman of the Entertainment Committee, advised that plans have been made to hold the Annual Banquet on Thursday Evening, November 20, at White Beaches Country Club, Haworth.

On recommendation of the membership committee, the following applicants were elected to full membership: DRS. CHARLES P. CAMPBELL, Hackensack; FRANK DREWS, JR., Leonia; JOHN F. FRIERY, Bergenfield; THOMAS A. GARRETT, Hackensack; STUART ALAN MASON, Ridgewood; ROY POLLACK, Cliffside Park, and EVERETT C. RAVITS, Hackensack, and LIVIO COSULICH, River Edge by transfer from Cayugo County, N. Y. DRS. VINCENT C. D'AGATI, Teaneck; ROBERT W. KRUDENER, Cliffside Park; HARRISON E. LAW, Closter; JAMES S. MEEHAN, Teaneck; LORENZO ORLANDO, Hackensack; CHARLES RENTROP, Ridgewood, and JOHN R. WILLIAMS, Cliffside Park, were elected to Associate membership.

Dr. George M. Knowles, Chairman of the Scientific Committee, introduced the following doctors, who formed the panel of the evening for round table discussion on the *Everyday Management of Psychosomatic Problems*: DRS. JOHN A. P. MILLET, Assistant Attending Physician, Presbyterian Hospital, N. Y. C., Instructor in Psychiatry, College of Physicians and Surgeons, New York City, Chief Psychiatrist, American Rehabilitation Committee; C. P. SEGARD, Medical Director, Wisconsin Research Foundation; VICTOR A. BLENKLE, Holy Name Hospital; S. A. SANDLER, Hackensack Hospital; J. L. EVANS, JR., Englewood Hospital; THEODORE R. FORD, Orange Memorial Hospital, Overlook Hospital, and others.

Dr. Millet introduced the subject by a short talk on *Nature of Psychosomatic Manifestations* and gave a brief historical survey of psychosomatic medicine from its origin as a clinical specialty with Dr. Deutsch in Germany, down to Dr. Flanders Dunbar, one of the current leaders in the field in the United States. He pointed out that psychosomatic medicine deals with the psychological approach to general medicine. He further stated that every physician practices psychosomatic medicine to a greater or lesser degree; the present day psychiatrist not attempting to foist his views on the medical profession—he recognizes his limitations fully. Among the highlights brought out was a differentiation between psychosomatic disorders and the pure psychoses. A psychosomatic disorder is usually a vegetative disturbance, whereas a psychosis has no immediate relationship with the vegetative function of the body. The secret of success in the practice of psychosomatic medicine lies in the special skill and training of the practitioner. There were many questions presented to the panel, which were evidences of the considerable interest in this subject on the part of the general membership of the Society. The presentations and answers were clear and well thought out. It was felt by everyone present that a great deal was accomplished by the panel, and a rising vote of thanks was given to the participants for their effort.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The November meeting of the *Burlington County Medical Society* was held on the 13th of the month at the Riverton Country Club and was presided over by the president, DR. E. WARREN RODMAN.

The scientific portion of the meeting was an address by DR. HOWARD M. HEBBLE of Moorestown on "Modern Concepts of the Treatment of Sinusitis". In his introduction he briefly described formations of the para-nasal sinuses and the ages at which they develop. In determining the etiology of sinusitis a good history and examination are necessary. The chief causes are allergy, head colds, and trauma. He stated that visual examination of the nose was probably the most important means of examination. This is accomplished by the nasal specula and nasopharyngoscope. Transillumination and x-ray are adjuncts to the above. The treatment of sinusitis has become more conservative in the last few years. About ten years ago a large amount of radical operative work was done on patients with sinusitis. It was found that these procedures would not accomplish the desired results. Therefore, they were stopped, and a conservative treatment substituted. The most important point in the treatment of this condition is that the physiological function of the nose must be maintained. Chemotherapy and antibiotics are playing an important role. At the present time radical surgery is reserved only for the extreme cases. Dr. Hebble then outlined the treatment of sinusitis in the home and office. He did not approve of using nasal tampons, irritating chemicals and x-ray therapy. His talk was very interesting and gave the members of the society a great deal of practical information which can be used in their practice.

The County Society enjoyed hearing a talk by MR. JAMES E. BRYAN, the new executive officer of the State Society, who was introduced by Dr. J. Howard Hornberger. Mr. Bryan said his chief job was, Public Relations which means "Be good, do good and tell the public about it". He stated that the County Society does not enjoy the same esteem in the public eye as the individual physician because it is only heard from when some subject or situation arises which it considers bad for the public and the medical society. The State Medical Society has

a very progressive attitude toward the problems of the present day and is trying to look ahead and anticipate new problems before they arise. Mr. Bryan mentioned seven plans with which the State Society is busy at the present time. The most important of these are: The Medical-Surgical Plan which is now well established; The Veteran's Care Plan which is running smoothly; and the Cancer Control Plan. The State Public Health Organization is being studied for more efficient and better service. In closing, Mr. Bryan said that the American Medical Association is beginning to recognize the important part which the general practitioner is playing and at its next meeting will present an award for the most typical general practitioner in the country. The State Society, at its annual meeting in April 1948, will likewise present an award to the most typical general practitioner in the state. In regard to both of these awards each County Society is requested to present a nomination. This is the first time that the County Society has had the executive officer of the State Society address the members. Mr. Bryan's talk was very informative and greatly appreciated.

A communication from the State Department of Health requests that all physicians do their utmost to control whooping cough by booster shots.

Under the new School Health Plan, Dr. Harry B. Mark was appointed consultant to the Woman's Auxiliary to the Society.

The proposed plan for medical care for recipients of Old Age Assistance and Aid to the Needy Blind through the Burlington County Welfare Board, which was discussed at the October meeting, was adopted. All bills will be reviewed by the Welfare Committee of the County Medical Society. Physicians will mail their bills to the Burlington County Welfare Board in Mount Holly as they have done in the past. These bills must be in the office of the Welfare Board not later than the fifth of the month. If a bill reaches this office after the fifth it will not be paid.

A committee on Medical Defense and Insurance was appointed and its members are Dr. George T. Tracy, Chairman, Dr. Alan M. Schaeffer and Dr. Harry B. Mark.

ESSEX COUNTY

Asher Yaguda, M.D., Reporter

The first monthly session of the *Essex County Medical Society* under the new president, Dr. Harold A. Murray, was in the form of a dinner meeting at the Hotel Essex House, Newark, Wednesday evening, October 22, 1947. About 300 members and their wives and guests were present for the dinner and many other guests arrived later in the evening in time to hear the speaker of the evening, Dr. Morris Fishbein of Chicago, editor of the Journal of the American Medical Association and Hygeia. A telegram from Governor Driscoll was read expressing his regrets at not being able to be present. During the dinner, the Essex County Male Choral Group entertained with several numbers.

The subject of the evening was "The Newer Aspects of Medical Economics". Dr. Fishbein, in a scintillating talk, outlined some of the advances in medical practice and their resulting effects upon medical economics. He discussed group medical practice, hospitalization plans and recently enacted legislation for the nationalization of medical service in Great Britain. One of the points stressed by Dr. Fishbein was the difference between the social medicine and socialized medicine. Dr. Fishbein stated that medical societies must provide the veteran doctor access for his patients in hospitals or we will be faced with socialized medicine. The shortage of nurses is another problem, which must be controlled if we are to avoid state medicine. In a comparison of medical care and population health in South America, Central America and the United States, Dr. Fishbein showed that where the tuberculosis death rate in South America was between 350 and 450 per 100,000 population, the death rate in New Jersey was only 43 per 100,000. He called attention to the fact that the two areas having the highest rates in the United States are the negro areas of Chicago and Newark. Similarly, the infant mortality rate in some South American countries was as high as 450 per 1000 births whereas in New Jersey the rate is 33 per 1000. The general practitioner was commended for constituting the most economic method for securing adequate care. In closing, Dr. Fishbein spoke about the formation of a world medical association for the promotion of world peace and interchange of medical knowledge.

GLOUCESTER COUNTY

L. K. Collins, M.D., Reporter

A large group of members greeted Dr. Joseph Hughes, as he presided at the regular monthly meeting of the *Gloucester County Medical Society* held November 20, at the Woodbury Country Club.

The society unanimously decided to write the Board of Freeholders concerning the present low fees for coroners cases, it being felt justifiable to ask for a return to the "pre-depression" rate of 20 years ago.

Although we have never been consulted as a body or asked to approve or assist with the proposed United Communities Hospital at Clayton, we were sorry to be notified that the project had been abandoned. Perhaps in the future with a more representative initiation and support, the plan could succeed.

Three new committees were appointed by the president, namely: Child Welfare, School Health, and Advisory to the Woman's Auxiliary.

The guest speaker of the evening was Dr. Abraham E. Rakoff, Associate in Obstetrics and Gynecology at the Jefferson Medical College of Philadelphia. Dr. Rakoff, who is chief of the Endocrine Clinic at Jefferson Hospital, spoke on "Endocrine Therapy in General Practice—Some Basic Principles". The various hormones, particularly of the pituitary, ovary, and testis were discussed as to their derivation, inter-relationship, structural formulae, production, function and therapeutic usage. Many simple as well as specialized laboratory technics are necessary when attempting to evaluate the endocrine pattern in a patient. The dosage,

efficiency and toxicity of the various natural and synthetic estrogens were thoroughly explained; progesterone and testosterone were exhaustively delved into as well. Many questions were ably answered by Dr. Rakoff before the meeting adjourned at a late hour.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society held its regular monthly meeting on November 5, 1947, at the Masonic Club in Jersey City. DR. RAYMOND S. DRISCOLL, presided.

Elected to membership were DRS. HAROLD B. BIEBER, CATHERINE H. BREWER, JOHN W. CARNEY and MICHAEL P. CERCHIO of Jersey City; DRS. JEROME M. CEBULA and WILLIAM G. GREENBERG of North Bergen; DRS. JOHN J. CHEZIK, JOHN G. LIONE and FRANK SCHWARTZ of Bayonne; DR. JOSEPH A. COLONNA of West New York; DR. SOL LEWIS KOOK of Arlington; and DR. DARWIN A. LEUZZI of Union City.

The guest speaker of the evening was DR. C. G. DE GUTIERREZ-MAHONEY, Neurosurgeon-in-chief at St. Vincent's Hospital in New York City, whose subject was *Neurosurgery: Its Place in a General Hospital.* In introducing his subject, Dr. de Gutierrez-Mahoney exhibited a series of kodachrome slides illustrating interesting neurosurgical lesions. He then described the widening sphere of neurosurgery today as it expands its usefulness from the area of the brain where it originated and gradually becomes integrated in the general field of medicine and in specialized fields. He discussed some of the special uses of neurosurgery; for example, its employment for the purpose of obtaining relief from severe pain, touching on the ethical aspects of such procedures and the moral responsibility that the neurosurgeon assumes. He also pointed up the desirability of close cooperation between the neurosurgeon and the other members of the hospital staff—and emphasized the major importance of correct and adequate nursing care following neurosurgery. Drs. Stockfisch, Judy, Madaras and Figurelli were discussants, Dr. Mahoney closing the discussion.

MIDDLESEX COUNTY

Carlyle Morris, M.D., Reporter

The regular monthly meeting of the *Middlesex County Medical Society* was held on October 15, 1947, at the Roosevelt Hospital, Metuchen with DR. FREDERICK TABER, President, presiding. This meeting, as planned, was devoted entirely to consideration of business. During the preceding months a study to revise the Constitution and By-Laws, and Principles of Medical Ethics, was made and committees, under the chairmanships of Dr. Marshall Smith and Dr. F. M. Hoffman, rendered their reports.

Each proposed change was considered by the Society as a whole and discussion was free as is proper in changing the Constitution and By-Laws of one of the oldest county medical societies in the United States. Further changes were suggested and a special meeting is called for November 5, to continue the discussion of the revised constitution and by-laws prior to adoption.

The following Associate Members, having been members in the Society for two years and in good standing, were elected to full membership: DR. MILES HAMBURG, Highland Park; DR. ROBERT KOENIG, Jamesburg; DR. C. F. CHURCH, New Brunswick, and DR. PAUL WIESENFELD, Perth Amboy.

DR. JACK E. SHANGOLD, Perth Amboy, was elected to Regular Membership on transfer from the Hunterdon County Medical Society; DR. RUSSEL A. BARNHART, Parlin, was elected to Regular Membership on transfer from the Allegheny County Medical Society, Pittsburgh, Pa.

The following physicians were elected to Associate Membership: DR. WILLIAM S. ITTLEMAN, Dunellen, and DR. EDWARD A. JASIONOWSKI, Sayreville.

A sum of forty dollars was authorized by the Society to be expended for the purpose of compiling data on the subject of socialized medicine, and of giving publicity to the facts in the argument for and against this plan of medicine. A form of Socialized Medicine in all probability will be considered by the Congress of the United States next year.

It was decided that there would be no change in the present yearly dues of thirty-five dollars; any member of military service who had previously paid dues for the current year would be credited with the sum in payment of future yearly dues; yearly dues would be refunded only to members who had permanently transferred their membership to other county medical societies.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

DR. WILLIAM GOLDRING presented a paper on "Present Status of the Medical and Surgical Treatment of Hypertension", at the regular monthly meeting of the *Monmouth County Medical Society* on October 22, 1947, at the Monmouth Memorial Hospital, Long Branch. The meeting was called to order by DR. LOUIS ALBRIGHT, and DR. VICTOR KNAPP introduced the speaker. Dr. Goldring is Associate Professor of Medicine, New York University College of Medicine and visiting physician, Bellevue Hospital, New York City.

Dr. Goldring first discussed the futility of the use of nitrites, thiocynates and other drugs in the treatment of hypertension. Not only is the effect of thiocynates slight and transient but they are highly toxic. These drugs should never be used in Dr. Goldring's opinion. The effect of pyogenic infections and artificial fever on hypertension was discussed. Other treatments such as foreign protein injection, methylene blue, injection of amines, injection of renal inhibiting substances and the rice diet were considered.

The futility of unilateral nephrectomy in cases of unilateral renal disease, except in those cases in which there is pressure on the main renal artery, was discussed. Dr. Goldring mentioned the fact that the blood pressure is always lowered for a short period of time in any nonspecific surgery. Sympathectomy was the final surgical procedure discussed. Its indications, procedure, and limita-

tions were considered. It is most successful in the early cases in which the blood pressure is liable and in which the hypertension would respond to bed rest. It is a non-specific remedy.

There is often no connection between the height of the blood pressure and the severity of the disease. The reduction of blood pressure is not the goal, but rather the relief of symptoms and the prevention of the progress of the disease.

The most satisfactory treatment of hypertension is at this time symptomatic treatments. The most important of these is probably psychotherapy. The patient must be reassured. The patient must develop a new philosophy of life and adopt a new way of life. Obesity, tobacco and tension must be avoided. A normal diet is all that is required and strict restriction is unnecessary. Any treatment that seeks to control the blood pressure alone is unsound.

The business meeting followed immediately. Dr. Norman Davis Thedford of Eatontown, was elected to Associate Membership. A few announcements were read and the meeting was adjourned.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held as a joint meeting with the New Jersey Chapter of the American College of Chest Physicians at Valley View Sanatorium on Tuesday, October 21, 1947. The meeting was called to order by our President, Leon E. De Yoe, M.D., who presided at the session.

At the business session, the following applicant physicians were elected to membership: *Active Membership,* Drs. Frederick M. Offenkrantz, Burton B. Pfeffer, and James Edson; *Associate Membership,* Drs. Stanley Gerson and Isadore Herman.

A report from Dr. Graham, treasurer, was read by Dr. Leach, secretary:

> A recommendation of the House of Delegates, The Medical Society of New Jersey, 1947 Annual Meeting—
>
> "All veteran medical officers who were members in good standing of The Medical Society of New Jersey at the time of entrance into military service shall be entitled to one full year's credit or remission of dues in addition to remission of dues during the balance of the year they were discharged."
>
> At the Welfare Council Meeting held on October 20, it was suggested that the County Society also refund its share of the dues for that year. This would require the withdrawal of some $1500 from the County Treasury and seriously deplete our reserve kept for emergencies.

After discussion, it was decided that the County Society would retain its share of the dues, the refund being made only of the State Society's share of the dues.

After the business session, Dr. De Yoe introduced the speaker of the evening, Benjamin P. Potter, M.D., Chief, First Division, B. S. Pollak Hospital for Chest Diseases in Jersey City. Dr. Potter's paper covered many interesting cases, which he illustrated with lantern slides. He discussed each case, giving history, diagnosis, prognosis and treatment whether medical or surgical. His paper was well received and much discussion followed.

NEW JERSEY MEDICAL WOMEN'S ASSOCIATION

Virginia Wuerthele, M.D., Secretary

The fall meeting of the *New Jersey Medical Women's Association* was called by the President, Dr. Elizabeth R. Brackett, of Nutley, on Saturday, November 8, at Princeton, N. J. A business meeting was followed by a luncheon for the members. The afternoon program consisted of the following reports of original investigations:

Influenzal Meningitis

- Research Aspects—Dr. Margaret Smith, Princeton—Rockefeller Institute.
- Clinical Aspects—Dr. Jeannette Munro, Princeton.
- Discussion—Dr. Olga Haller, Newark.

Mycobacterial Diseases

- New Staining Method—Dr. Eleanor Alexander Jackson, Bacteriologist, Cornell University Medical College, N. Y.
- Use of Sulfones in the Treatment—Dr. Virginia Wuerthele-Caspe, Newark.
- Discussion—Dr. Camille Mermod, Newark.
- Comment on the International Meeting of the Medical Women's Association held at Amsterdam—Dr. Helen Schrack, Camden; Dr. Margaret Wurts, Montclair.

NEW JERSEY OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Bemjamin Daversa, M.D., Secretary

The *New Jersey Obstetrical and Gynecological Society* held its first semi-annual meeting on October 2, 1947, at the Margaret Hague Maternity Hospital in Jersey City. About 100 members of the Society (representatives from the entire state) were greatly impressed by the all day conference presented by Dr. Samuel A. Cosgrove and the staff of the hospital. The morning session on the *Toxemias of Pregnancy* aroused much interest. The subject was most clearly and thoroughly presented by Dr. James Norton. The membership was particularly fortunate in being able to see Dr. Edward Waters perform an extra-peritoneal Cesarian Section. The subject of *Myomata Uteri* complicating pregnancy was aptly presented by Dr. Samuel A. Cosgrove, who advised an attitude of conservatism. Drs. Leon Chesley and Nicholas Alter were also effective in their respective subjects of bio-chemistry and pathology.

The entire day was spent in a thoroughly pleasant atmosphere and everything was done to make the visitors comfortable, including a fine luncheon.

At the business session which terminated the day, it was announced that 182 applicants to the Society had been accepted as Charter Members. The Society has apparently filled a need in the State of New Jersey for the association of obstetricians and gynecologists, as evidenced by the continued interest of new members calling for application blanks.

WOMAN'S AUXILIARY

CHRISTMAS MESSAGE

To be merry this Christmas one cannot be gifted with broad vision of what the world is facing, but must follow blindly the dictates of a selfish heart. For the world cannot have health until it has peace. God grant that our organization may, in some small way, be allowed to work for these ideals this coming year, and thus find the merriment of heart that comes from service to others.

Frances Mancusi-Ungaro, President

PRESIDENT'S MESSAGE

The interest shown by many County Auxiliaries in the problem of student nurse recruitment is very gratifying. Five Auxiliaries have or are starting scholarships for nurses, and this type of activity should be encouraged in all counties. This exacting profession gives inestimable help to our husbands and relieves them of many tedious details of the care of the sick. The encouragement of girls to enter this noble profession should be one of the prime objectives of this regime.

Another altruistic objective should be the promotion of *Hygeia*, the magazine which presents health information to the lay public in the manner in which the American Medical Association thinks it should be set forth. Each County Auxiliary is urged to see that this publication is in the libraries of the secondary schools of its county, in order that authentic articles on health be made available to all of the children of our State.

Frances Mancusi-Ungaro.

AUXILIARY REPORTS

Atlantic County

Mrs. Matthew Molitch
Chairman, Press and Publicity

A very interesting meeting of *The Woman's Auxiliary to the Medical Society of Atlantic County* was held October 10, 1947, at the Hotel Traymore at which the society was honored by the presence of the President of the Auxiliary to The Medical Society of New Jersey, Mrs. Lodovico Mancusi-Ungaro, and its President-elect, Mrs. Robert Walker.

Mrs. Edward H. Dyer, president of the local society, called upon Mrs. Mancusi-Ungaro to speak. The latter emphasized the importance of public relations as a means to establishing firmer relations between the medical profession and the laity. The main function of a public relations committee is to educate the people to demand minimum health standards. Mrs. Mancusi-Ungaro stated that every member of the Auxiliary should have a thorough knowledge of what is going on in the community, state, and country.

The President of the Medical Society of Atlantic County, Dr. Clarence B. Whims, in his words of greeting to the Auxiliary, asked for the women's cooperation in the two projects which the county has set for itself for the coming year: 1. to improve the medical care in the schools of Atlantic County; 2. to establish an elaborate mental hygiene clinic in Atlantic County.

A very entertaining program was enjoyed by the members of *The Woman's Auxiliary to the Atlantic County Medical Society* at their November 14th meeting, when the Reverend Arthur J. Blythe reviewed thoroughly and delightfully the book, "The Prince of Foxes", by Samuel Scheilenberger.

Mrs. Edward H. Dyer presided over the important business meeting. A new constitution was adopted for the Auxiliary.

Mrs. G. Ruffin Stamps announced that a series of radio programs, sponsored by the Medical Society of Atlantic County and Station WFPG, will be heard over that station every Monday evening at 10:00 p. m. for the next twelve weeks. The series is entitled "Melody of Life" and each program is a fifteen minute presentation of the life stories of musical masters, with organ selections of their music and information on how their health problems could have been relieved today.

Mrs. Samuel L. Salasin presented the new project for the Auxiliary which is to establish a scholarship fund to assist a worthy and needy nurse in training with a fixed sum each month during the training period and to make a cash award to a graduate nurse desirous of furthering her education. Members of the Scholarship Fund Committee are Mrs. Salasin, Mrs. James Mason, Mrs. G. Ruffin Stamps, Mrs. Charles Hyman, Mrs. Ily Bier, and Mrs. Robert Bradley. Mrs. Irving Shavelson, Chairman of Ways and Means, announced that a Sweepstakes Dance will be held in the Spring for the benefit of this fund.

Mrs. Dyer appointed the following committee to assist in the Nurse Recruitment Campaign: Mrs. Clarence B. Whims, Chairman, Mrs. I. E. Leonard, Jr., Mrs. Jean Gruhler, Mrs. Lawrence Wilson, Mrs. Samuel M. Diskan, and Mrs. Irving Shavelson.

Camden County

Mrs. Wilmer F. Burns
Chairman, Press and Publicity

The Woman's Auxiliary to The Camden County Medical Society resumed activities on October 7, 1947, when the first regular meeting was held at the home of Mrs. Robert S. Gamon, Merchantville.

Dr. James S. Shipman, President of The Camden County Medical Society, extended greetings to the group.

After welcoming the guests and members, Mrs. Arthur G. Pratt, President, conducted a business meeting.

One worthy philanthropic project was accepted as a goal for the Auxiliary this year. Funds to accomplish this plan will be raised by members having small card parties, the first to be held November 10.

Mrs. Arthur J. Casselman read a resolution in memory of Mrs. A. Haines Lippincott.

Mrs. Harold D. Barnshaw, of Merchantville, Program Chairman, presented as honored guest and speaker, Mrs. Mancusi-Ungaro, President of the State Auxiliary, who stressed the promotion of health education as the Auxiliary's principal objective for the coming year.

Additional guests included Mrs. Robert Walker, President-elect of the State Auxiliary; Mrs. Chester I. Ulmer, President of the Auxiliary to the Gloucester Medical Society and Mrs. E. Vernon Davis, President of the Burlington County Auxiliary.

Nurse Recruitment was the theme of the Annual Health Institute of the *Woman's Auxiliary of The Camden County Medical Society* held October 28, 1947, at the Haddon Fortnightly, Haddonfield.

Greetings were extended by the President, Mrs. Arthur G. Pratt; Dr. James S. Shipman, President of the Camden County Medical Society; Dr. Robert S. Gamon, Advisor to the Auxiliary, and Mrs. Mancusi-Ungaro, President of the State Auxiliary.

The program was arranged by Mrs. Karl S. Russell, who introduced the speaker, Sister Mary Elaine, Director of the School of Nursing at St. Francis Hospital, Trenton. Sister Elaine outlined a course for student nurse recruitment. Enlisting the support of the clergy, professional groups, local organizations and veterans service clubs will be a great aid in this enrollment program she said. The organization chart was distributed at the meeting so everyone has a concrete plan to follow in launching a campaign for student nurses. Her collection of authentically costumed dolls depicting the history of nursing from the time of Christ to the present day was displayed.

Cape May County

Mrs. Thomas H. McGlade
State Chairman, Press and Publicity

The Douglass Hotel, Wildwood, N. J., was the scene of the Reorganization Meeting of the Cape May County Auxiliary.

After a delightful luncheon, Mrs. Thomas P. McConaghy, Organization Chairman, welcomed those present. Dr. J. S. D. Eisenhower, president of the Cape May County Medical Society, was then introduced. Dr. Eisenhower stated that the Medical Society approved of the Auxiliary and needed the organization. He suggested they act as a public relations group being a link between the medical group and the public.

Mrs. Lodovico Mancusi-Ungaro, president of the Woman's Auxiliary to The Medical Society of New Jersey, spoke on the values and objectives of an Auxiliary. She stressed that the work carried on by the Auxiliary is only done with the cooperation and approval of the Medical Society.

Mrs. Frederick G. Wandall, past president of the State Auxiliary, gave words of encouragment to the new members.

The reorganization meeting was called to order by Mrs. Thomas P. McConaghy. Mrs. C. Chester Chianese, Co-Chairman of Organization, was appointed temporary secretary.

The text of the Auxiliary Constitution was read and accepted.

Nominations and election of officers were next on the agenda, with the following being duly elected:

President, Miss Esther Dandois; President-Elect, Mrs. Paul L. Yingling; First Vice-Presdent, Mrs. J. S. D. Eisenhower; Secretary-Treasurer, Miss Gwen Pettit.

Directors: One Year—Mrs. John B. Townsend, Mrs. Frank R. Hughes; Two Years—Mrs. Marcus A. Fath, Jr., Mrs. Benjamin Gidding; Three Years—Mrs. George M. Brooks, Mrs. Samuel Mazotti.

Mrs. Lodovico Mancusi-Ungaro declared the county organized under the name of the Woman's Auxiliary to the Cape May County Medical Society. The business having been completed, the meeting was adjourned.

Essex County

Mrs. Asher Yaguda
Chairman, Press and Publicity

A luncheon meeting, held on October 27, 1947, marked the opening of the business year for the *Woman's Auxiliary to the Essex County Medical Society*. Guests were Mrs. Mancusi-Ungaro and Mrs. Walker of State Auxiliary fame, and Dr. Royal A. Schaaf, president of The Medical Society of New Jersey, Dr. Harrold A. Murray, president of the Essex County Medical Society, Dr. Clymont L. MacArthur, president of the Academy of Medicine of Northern New Jersey, (which is the permanent home of the Essex Auxiliary) and Dr. George Blackburne, chairman of the Woman's Auxiliary Advisory Committee of the County Society.

Mrs. Mancusi-Ungaro was the principal speaker and stressed the importance of the legislative program of the State Auxiliary, the *School Health Program*, the placement of Hygeia in the public high schools of New Jersey as an Auxiliary contribution to proper source of health education for the laity, greater utilization of the Auxiliary for friendship among wives of physicians and the need for the New Jersey component groups to strive to attain the quota of 1000 new members this year, to meet the goal set by Dr. Bortz, president of the A.M.A.

Dr. Murray complimented the Auxiliary mem-

bers on their assistance, and their part in the Health Week Program and requested continued cooperation between the Society and the Auxiliary.

The regular business meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held on November 24, 1947, with Mrs. Daniel E. Kavanaugh presiding. A fifteen minute summary of medical legislative matters was given, followed by discussion on the Essex County plan of School Health, the sale of seals for the Tuberculosis League, Hygeia, National Bulletin, Membership and a request by Mrs. Jerome G. Kaufman, chairman of the blood bank committee, that the members cooperate in providing the sixty donors pledged to the Essex County Blood Bank for December 23rd.

Dr. Gerald W. Hayes, who has contributed much toward maternal welfare in Essex County, presented a film and a very interesting talk on "Maternal Care". This type of program, covering medical subjects, is appreciated by the Auxiliary members as it is helpful in promoting a better understanding of the scientific achievements of the men in our County Society.

Dr. Henry G. Smith, a physician with a serious hobby of collecting antiques, was presented by Mrs. Frank Bien, program chairman, and he showed color film and spoke on the topic of "Wedgewood". Dr. Smith exhibited some small examples of his collection which dates back to 1760, and which has been displayed at both the Newark and Montclair museums. He is at present president of the Antique Club of New Jersey and Dr. Smith gave freely of his expert opinion on examples of Wedgewood brought in by the audience.

Hudson County

Mrs. Louis F. Marrella
Chairman, Press and Publicity

Under the chairman of Mrs. Louis F. Perkel, the *Woman's Auxiliary to the Hudson County Medical Society* held its first regular meeting of the season on October 6, 1947, at the Y.M.C.A., Jersey City, welcoming 23 new members, the largest group in the history of the auxiliary.

Mrs. Perkel briefly outlined the scope of the auxiliary and the social program to be achieved for the year. Among these are plans for a dinner dance, a card party, an open forum meeting, and a choral group with professional instruction.

Guests present were: Mrs. Mancusi-Ungaro, state president, who briefly addressed the group on public and social relations; Mrs. Robert Walker, state president-elect; Dr. Raymond Driscoll of Bayonne, president of the Hudson County Medical Society, who pledged to the auxiliary the cooperation of the society with the naming of an advisory board.

"Juvenile Delinquency" was the theme of the program by the *Woman's Auxiliary to the Hudson County Medical Society,* held November 6, 1947, at the Y. W. C. A., Jersey City.

Mrs. William J. Gleeson, first vice-president, presided in the absence of Mrs. Louis Perkel, president.

The speaker of the afternoon, Mr. Vincent J. O'Shea, gave a talk on "Juvenile Delinquency and How Jersey City Works to Prevent It".

The following new members were introduced: Mrs. Marshall Bergen, Mrs. Joseph Vebar, Mrs. Edwin Mackowsky, Mrs. Sol Furmann, Mrs. Louis Ambur, Mrs. Fred Sacks, Mrs. Benjamin Starr, Mrs. L. Kimmel.

Mercer County

Mrs. Joseph R. Burns
Chairman, Press and Publicity

The Executive Board of the *Woman's Auxiliary to the Mercer County Medical Society* were guests of Mrs. Ernest Purcell, President, for luncheon at the Trenton Country Club on September 16, 1947.

Following the luncheon a business discussion was held. The third Monday of October, December, February and April were designated as regular meeting dates.

Mrs. Purcell urged members to participate in the local National Health Week programs.

A new committee of Social Relations was created. Mrs. LeRoy Wilkes was appointed Chairman.

The regular meeting of the *Woman's Auxiliary to the Mercer County Medical Society* was held at the Medical Society Building on Tuesday, October 21, 1947, at 2 o'clock.

Mrs. Ernest Purcell, president, welcomed the members to the first meeting of the season.

A moment of silence was observed for Mrs. Charles Adams, who was a charter member of the society.

Mrs. John Kustrup, chairman of entertainment, reported plans for the annual dinner dance.

A motion was made and carried to bill the members for their dues.

Following the business meeting, Mrs. C. Chester Chianese, program chairman, introduced Mr. James E. Bryan, Executive Officer of The Medical Society of New Jersey. Mr. Bryan discussed in detail the four-point program for better school health and our public relations opportunities through the use of the radio.

Beginning November 10, on Monday mornings at 9:15 the Trenton Broadcasting Station WTTM will present a program as a public service, sponsored by the Mercer County Medical Society and The Medical Society of New Jersey called "Live and Like It". The members were asked to help build a listening audience.

Middlesex County

Mrs. Robert B. Walker
Chairman, Press and Publicity

Mrs. Durand Taylor of South Orange was guest speaker at the first monthly meeting of the *Woman's Auxiliary to the Middlesex County Medical Society,* held in the form of a membership tea, at the home of Mrs. Ralph J. Faulkingham, New Brunswick.

Mrs. Taylor, a state trustee and member of the lecture board of the American Association of the United Nations, a fellow in the American Academy of Political and Social Sciences and a member of the Foreign Policy Association, the League of

Women Voters, and the Girl Scouts of America's regional council for world citizenship, spoke on "World Citizenship".

Sixty women attended the meeting. Seven new members were welcomed by the president, Mrs. Nathan Karshmer, and many old members who have not attended for years were reactivated.

"Nurse Recruitment" was the topic of a panel discussion led by Miss Enn M. Brogan, assistant director of St. Peter's Hospital School of Nursing, at the meeting of the *Woman's Auxiliary to the Middlesex County Medical Society,* November 19, 1947, at the home of the president, Mrs. Nathan Karshmer, New Brunswick. Miss Doris Carsey, instructor of nursing art at Middlesex General Hospital and Miss A. E. Plikunas, director of nurses at Perth Amboy General Hospital, also participated in the panel which was planned to investigate a nursing scholarship to be given by the Auxiliary.

Miss Brogan has been associated with St. Peter's Hospital since 1941 and holds her master's degree from New York University. Miss Carsey, a graduate of Middlesex Hospital, has been an instructor there for the past three years. She is also enrolled in the extension school of Rutgers University.

The membership chairman reported thirty-one new members.

Ocean County

Mrs. Harvey Rinzler, Chairman of Publicity

Ye Olde Cedar Inn, Toms River, was the meeting place of the *Woman's Auxiliary to the Ocean County Medical Society* on November 12, 1947. Present for this regular monthly session were: Mrs. William E. Dodd, Mrs. A. Taylor, Mrs. J. Goldstein, Mrs. J. Taylor, Mrs. F. Szold, Mrs. A. Towbin, Mrs. F. Bunnell, Mrs. I. Menge, Mrs. H. Rinzler, Mrs. H. Obert, Mrs. G. Jaffee, Mrs. R. Gove and Mrs. William Gebele, Jr.

After an enjoyable dinner, the business meeting was conducted by the president, Mrs. A. Taylor, who reviewed her activities for the year and called for committee reports. Mrs. J. Goldstein, who had attended the state meeting in Trenton in October, highlighted the accomplishments of that affair, with the attention to the various ways each county can carry out the ideals of the state society in such projects as public health, school health work, and publicity for the lay people.

Reporting on the condition of the treasury, Mrs. A. Towbin stated that $450.00 had been raised by the individual members of the Auxiliary during the past month, which money will be presented to Paul Kimball Hospital to aid in the purchase of new hospital equipment. This is to be the first of several projects the Auxiliary intends to direct for the benefit of Lakewood's hospital.

Passaic County

Mrs. Joseph E. Mott, Reporter

The *Woman's Auxiliary to The Passaic County Medical Society* held its first meeting of the season at the home of Mrs. William Marrocco on Monday, October 20, 1947, at 2:30 p. m., with the president, Mrs. Albert G. Markel, presiding.

The Auxiliary was honored by the presence of our charming and competent State President, Mrs. Lodovico Mancusi-Ungaro, who spoke to us on the aims and ideals of the Auxiliary; and by the presence of our gracious State President-elect, Mrs. Robert Walker, who spoke briefly.

Reports were given by the chairmen of all committees.

Following the business meeting a membership tea was given in honor of our new members.

There were 40 members present.

Union County

Mrs. Herschel S. Murphy
Chairman, Press and Publicity

The *Woman's Auxiliary to the Union County Medical Society* held an all-day outing at the Plainfield County Club, on October 2, 1947. Mrs. B. J. Sauerbrun, Program Chairman, was in charge of arrangements; Mrs. Victor deBusc, reservations; Mrs. W. L. Rumsey, transportation; and Mrs. William C. Meineke, prizes.

Golf and tennis were planned for the morning activity. Luncheon was served at one-o'clock. Following this Mrs. W. O. Wuester, President, conducted a short business meeting.

At the conclusion of the business meeting, Mrs. Wuester introduced the afternoon speaker, Miss Charlotte B. McCracken, Director of the Elizabethtown Chapter of the Red Cross, who told the group about the work of the Grey Ladies at Halloran Hospital on Staten Island. Union County Auxiliary expects to assist in this work as one of its projects for the year.

Flowers were sent to Mrs. Charles Schlichter, long an active member, who is ill. Mrs. Edgar Weigel received a basket of fruit in recognition of her work as historian.

School Health Program was the theme of the meeting of the *Woman's Auxiliary to the Union County Medical Society,* held at the Echo Lake Country Club in Westfield on October 28, 1947. The Public Relations Committee under the leadership of Mrs. J. E. L. Imbleau, Chairman, was in charge of the meeting.

Mrs. William Wuester, President, conducted a short business meeting, at which time, Mrs. W. L. Rumsey, Jr., Membership Chairman, greeted the members and expressed delight over the rapidly growing membership. Fifty-two members were present. Mrs. Bertram J. Sauerbrun, announced the next meeting would be held on November 18, at the Blue Hills Plantation in Dunellen, at which time there would be a reception for State Officers, and also a fashion show.

The speaker of the afternoon, Mr. James E. Bryan, Executive Officer of The Medical Society of New Jersey, gave a talk on Public Relations in the Field of Medicine.

Tea was served, with Mrs. George Knauer of Elizabeth and Mrs. E. M. Staub of Westfield, Past-Presidents of the Union County Auxiliary, pouring.

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OF

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HENRY A. DAVIDSON, M.D., *Editor*

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Editorial Office
315 WEST STATE STREET
TRENTON 8, N. J.

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The Official List of Members and Fellows will be found as the Supplement to the April issue. The Transactions of the Annual Meeting appear as a supplement to the August issue.

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† Obituary
e—Editorial
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Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XX December, 1947 No. 12

BCG VACCINATION

THERE was a time when even to mention the use of BCG vaccination as a protection against tuberculosis provoked violent controversy. This procedure, introduced in France after the first World War, employs as a vaccine, an attenuated strain of the tubercle bacillus known as Bacillus Calmette Guerin to build up resistance to more virulent organisms of the same species. The lack of controls and of adequate statistical evidence in the early work in Europe made American students of tuberculosis understandably cautious in their acceptance of BCG. Moreover, there was ample evidence that the methods of control already in use in the United States were doing more to control tuberculosis than even its most ardent proponents could claim for BCG vaccination.

That BCG is again being discussed as a practical public health measure is due largely to the recent publication of four experimental studies which seem to show that BCG may have real value under certain circumstances. Aronson and Palmer have reported favorably on six years' experience with a group of North American Indians who were vaccinated with BCG.

The experience of Ferguson who used BCG vaccine with the nurses and attendants in eight general hospitals and tuberculosis sanatoriums in the province of Saskatchewan, Canada, seems to show that BCG immunization is effective in affording a measure of protection to groups subjected to special hazard.

Holm has reported beneficial results from the use of BCG in Denmark where it is employed extensively with tuberculin negative individuals to prevent dangerous primary infections. During the course of immunization, the tuberculin reaction usually changes from negative to positive.

In contrast to these findings, Levine and Sackett, who studied carefully the results of vaccinating several hundred New York City infants, concluded that "as a public health measure the routine vaccination with BCG of children from tuberculous homes is probably of less advantage than removing the tuberculous case from the home."

As a result of accumulated new evidence the Tuberculosis Control Division of the U. S. Public Health Service invited leaders in tuberculosis work to a conference on BCG vaccination, held in Washington, D. C., on September 7, 1946. The purpose was to evaluate the reported studies with BCG so as to determine what use, if any, could be made of this procedure and what conditions would be most favorable for its employment.

Those attending the conference were: Dr. J. Burns Amberson, College of Physicians and Surgeons, Columbia University, New York; Dr. Joseph D. Aronson, Henry Phipps Institute, Philadelphia; Dr. Howard W. Bosworth, Barlow Sanatorium, Los Angeles; Dr. Charles A. Doan, College of Medicine, Ohio State University, Columbus, Ohio; Dr. Johannes Holm, State Serum Institute, Copenhagen, Denmark; Dr. Esmond R. Long, Henry Phipps Institute, Philadelphia; Dr. Jay A. Myers, University of Minnesota, Minneapolis; Dr. David T. Smith, Duke University, Durham, N. C.; Dr. Henry Stuart Willis, West North Carolina Sanatorium for the Treatment of Tuberculosis, Black Mountain (formerly of William H. Maybury Sanatorium, Northville, Mich.); and Dr. I. C. Yuan, National Institute of Health, Nanking, China.

The Public Health Service was represented by Doctors Herman E. Hilleboe and Carroll E. Palmer of the Tuberculosis Control Division, and Dr. Milton V. Veldee, Biologics Control Labora-

tory of the National Institute of Health, Washington, D. C.

During the conference a careful review of all investigations with BCG was made and there was a general discussion of the entire problem of BCG vaccination. It was agreed that there have been no proved cases of progressive tuberculosis from BCG vaccination. It was concluded that BCG vaccination appears to confer increased resistance to tuberculosis for the relatively short period of time covered in the studies.

The following conclusions and recommendations were made by the conference and the policy outlined was later approved by Surgeon General Thomas Parran for the U.S.P.H.S.:

1. BCG vaccine should not be made commercially available at present.

2. From studies presented at the conference, it appears that BCG vaccination confers increased resistance to tuberculosis for the limited period of time covered in these studies.

3. Medical literature fails to reveal any proved cases of progressive disease as a result of BCG vaccination.

4. BCG vaccination (properly administered) can be done without causing severe local reactions.

5. The intracutaneous method of vaccination is recommended for use at present.

6. In the studies presented, BCG vaccination converted a large percentage of nonreactors (to the tuberculin test) into reactors.

7. Need for revaccination and time interval between vaccination require further study.

8. It was recommended that a single laboratory be established by the Tuberculosis Control Division to produce BCG vaccine for the whole country for use in research programs proposed at this conference. (The daily press has since reported that the designated laboratory is that of a new tuberculosis research hospital to be constructed by the University of Illinois professional schools, in Chicago.)

9. Extensive investigations should be carried on cooperatively with recognized research groups throughout the country during the coming years, especially in population groups highly exposed to tuberculosis infection.

10. It was recommended that the Tuberculosis Control Division set up a controlled study in a community containing 100,000 or more people, to determine immediate and long-range results.

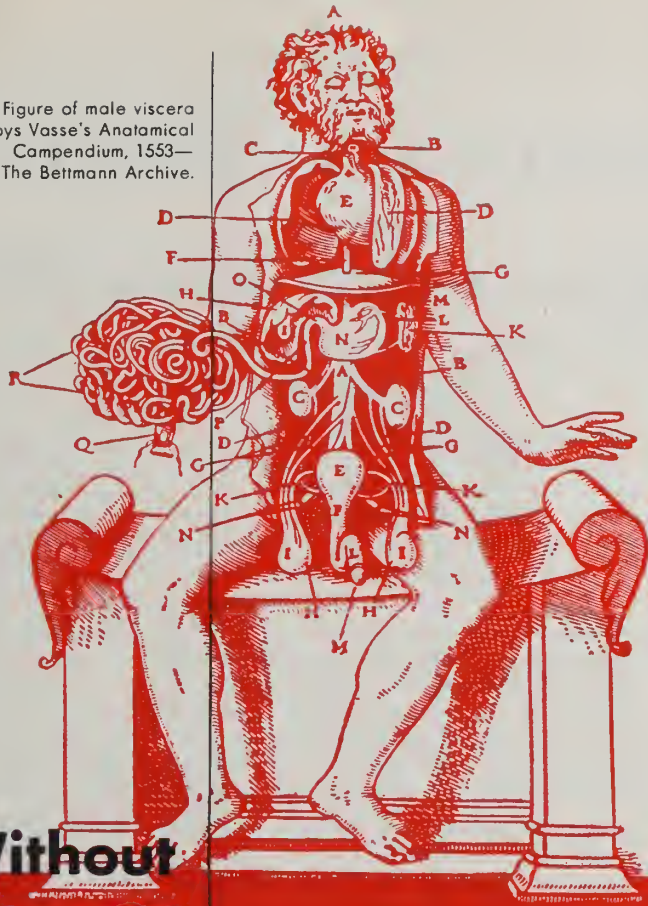
11. Further research is strongly recommended to determine the efficiency of the vaccination and also to attempt to develop a vaccine composed of dead bacilli. It was recommended that methods be developed to standardize techniques of preparation of a potent and stable vaccine for use in the United States and if possible throughout the world.

The way has now been cleared for an extensive study of BCG in this country. With special groups such as the North American Indians, inmates and employees of mental hospitals and certain racial and professional groups where the morbidity and mortality from tuberculosis are known to be high, there now seems justification for a trial of BCG. It is not expected to take the place of known and proved methods for controlling tuberculosis—but BCG may well be an added weapon against an old enemy.

Suggested Reading:

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6. Preas, Sally, Milbank Mem. Fund. Quar., April, 1947, 25:215.
7. Editorial, Amer. Jour. Pub. Health, March, 1947, 37:307.
8. Editorial, J.A.M.A., Nov. 9, 1946, 132:581.

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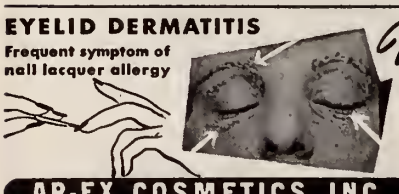
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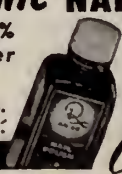
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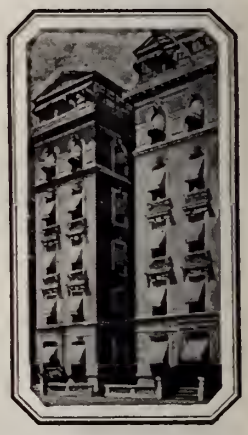
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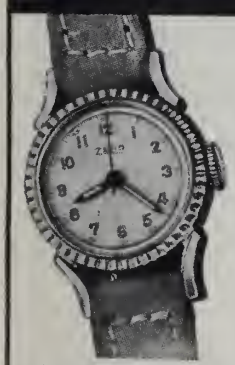
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